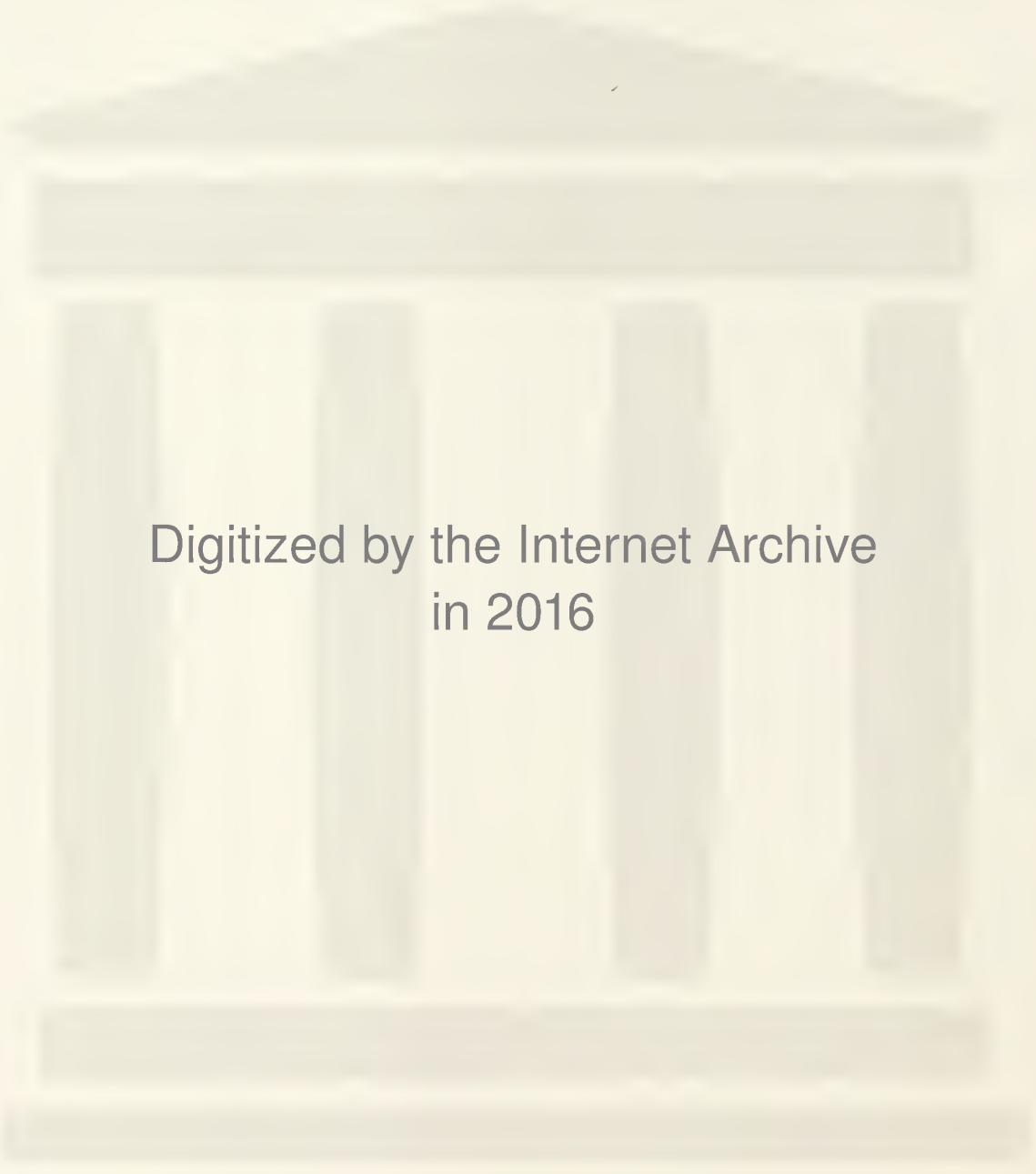
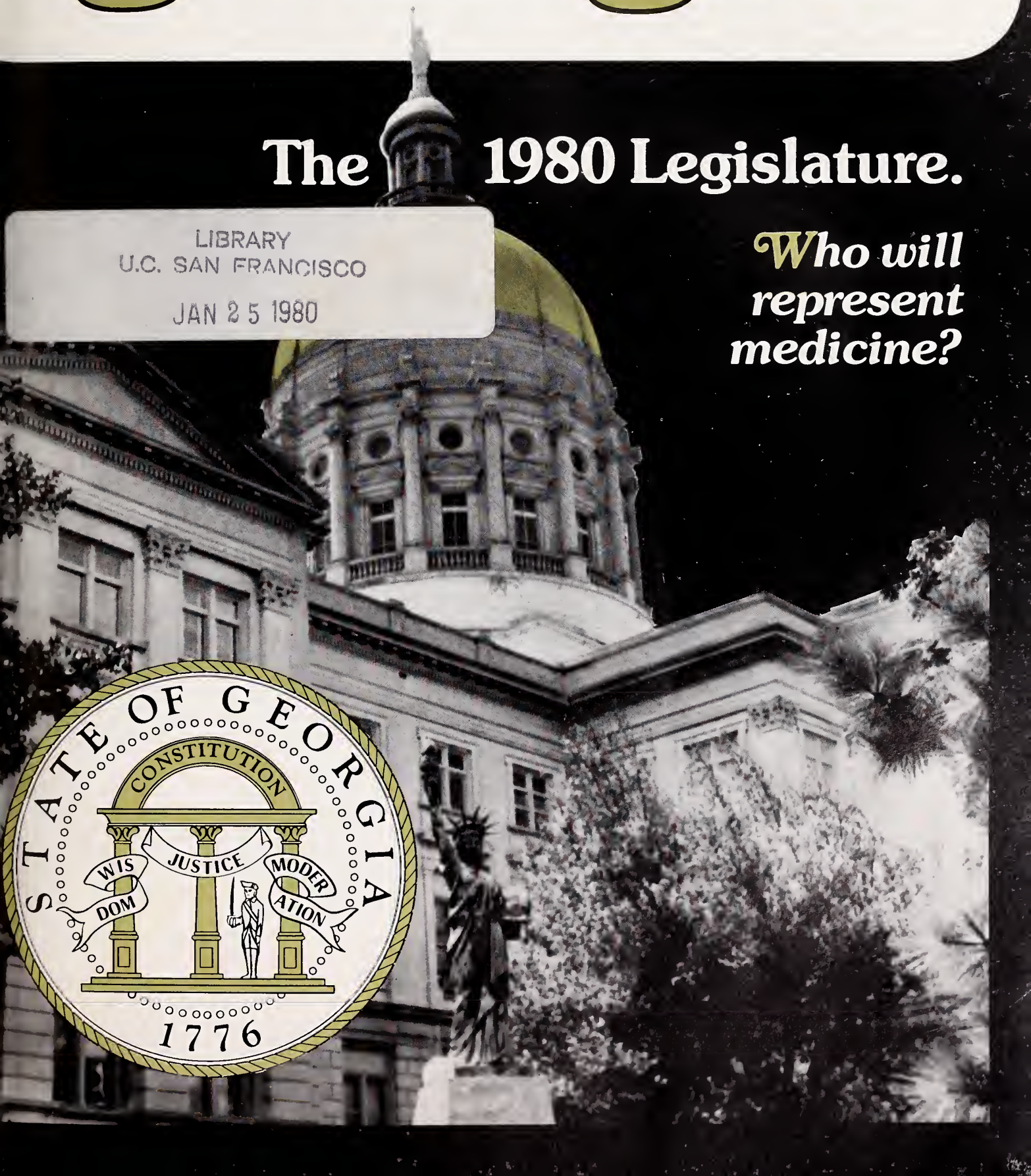
UC San Francisco LIBRARY
San Francisco LIBRARY
UNIVERSITY OF CALIFORNIA


Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmedical69medi

JOURNAL
of the medical association of
georgia
ISSN-0025-7028 JANUARY / 1980

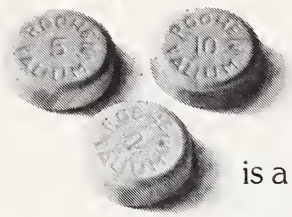


The 1980 Legislature.

Who will represent medicine?

LIBRARY
U.C. SAN FRANCISCO
JAN 2 5 1980

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

WE BUILD MEDICAL OFFICES



Architectural

Engineering

Construction

Financing

One Guaranteed Price — No Cost Overuns

We can put together, for you, the Complete Program: DESIGN - DEVELOPMENT - SITE SELECTION - CONSTRUCTION. All work done by professionals under the supervision of State Registered Architects-Engineers and Bonded Contractors all for one guaranteed price. Quality construction, low maintenance and operating costs are built into every building.

For More Information and Preliminary Estimates, Call or Write:

Robert G. Brownlow, President

MEDICAL BUILDINGS AND EQUIPMENT COMPANY, INC.

4399 Atlanta Highway • P. O. Box 305 • Loganville, Georgia 30249 • 404/466-2277

TEST DRIVE THE LUXURY COUPE THAT'S AS EXCITING TO DRIVE AS IT IS TO SIT IN.

Get our quote on your next lease. No leasing company can beat our rates. Nobody can beat our service. Lease or purchase your car from us and be assured of "no hassle" service. Our customers come first.

Leasing and Sales.





GLOBAL IMPORTS

225 PHARR ROAD, N. E. / ATLANTA, GEORGIA 30305

TELEPHONE: (404) 261-9730



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 1

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

ADVERTISING REPRESENTATIVE
Mary Coté

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Peter L. Scardino, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
Earnest C. Atkins, M.D., Atlanta
President
H. Hilt Hammett Jr., M.D., La Grange
President-Elect
Carson B. Burgstiner, M.D., Savannah
Immediate Past President
Richard A. Griffin III, M.D., Cartersville
First Vice President
S. W. Clark, M.D., Waycross
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Stephen L. Daniel, Ph.D., Assistant Executive Director — Education
J. Tom Sawyer, Assistant Executive Director — Administration
Rusty Kidd, Director of Legislative Activities
Kenneth M. Williams, Director of Public and Professional Relations
Joyce Butler, R.N., Director of Medical Practice
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The Journal of the Medical Association of Georgia is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

13 Electrophysiological Diagnosis and Surgical Treatment of Recurrent Supraventricular Tachycardias Due to Wolff-Parkinson-White Syndrome
Joseph W. Rubin, M.D.
John P. Boineau, M.D.
Robert Stenson Jr.
23 Toxoplasmosis in Pregnancy: Clinical Viewpoint and Report of a Chronic Case in Pregnancy
William C. Tippins Jr., M.D.
27 Orbital Decompression and the Treatment of Orbitopathy in Graves' Disease
Clinton D. McCord, M.D., F.A.C.S.

SPECIAL ARTICLE

8 The 1980 Georgia General Assembly — Who Will Represent Medicine?
James A. Kaufmann, M.D.
Rusty Kidd

EDITORIAL

37 Commentary on Physician Advertising
Richard E. DuBois, M.D.

FEATURE PAGES

34 Legal Page/Informed Consent in Georgia: Previewing the "1980 Model"
Robert N. Berg
43 Heart Page/Nutrition and Maintenance of Cardiovascular Health
Sara M. Hunt, Ph.D.
47 Cancer Page/Reasons for Optimism in Childhood Cancers
Tae H. Kim, M.D.
Abdelsalam H. Ragab, M.D.
54 President's Letter/Setting the Record Straight
Earnest C. Atkins, M.D.

THE ASSOCIATION

6 Letters to the Editor
55 New Members
55 Personals
57 Societies
57 Deaths
64 The 1979 MAG Scientific Assembly
66 Physician's Recognition Award Recipients

NEWS

7 Medical Meeting Calendar
17 Post-Mortem Tragedies
67 Dr. David McClusky Receives American College of Surgeon's Award
68 Index to Advertising
68 Manuscript Information

COVER

Legislation is the featured subject of this month's issue. Dr. Kaufmann and Mr. Kidd have written a brief article highlighting some of the important issues. Read their article and get involved. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

370971

Letters to the Editor . . .

The 1979 MAG Scientific Assembly — Participants Respond

Dear Sir:

I feel continuing medical education is closely connected with good medical care of the patient. The symposium on "Present Advances in Medical Transfer and Technology" was most stimulating and informative. The speakers were excellent and experts in this field. Some of the programs outlined are not as yet available for the practitioner, but further advances in computers and artificial intelligence systems are in the offing. As a practitioner, the symposium has stimulated my interest in all the methods by which further information and education is available.

Sincerely yours,
L. Harvey Hamff, M.D.
Atlanta

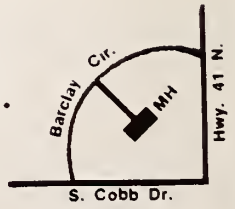
Dear Sir:

As one with long experience in attending continuing medical education meetings, I feel qualified to judge MAG's 1979 Scientific Assembly as easily the best ever. Audience participation was encouraged in panel discussions, and after the lecture in question-answer periods. These were handled very well by the presiding physicians. My thanks to Drs. Alan Plummer, W. Newton Turk III, and Neil Kelley for their efforts in planning the Chest Disease segment of the meeting.

Sincerely,
Bernard P. Wolff, M.D.
Atlanta



Elegant Dining, Country Simplicity
Reservations accepted until 9
404/422-2267 1266 Barclay Circle S.E.
Marietta, Georgia



MEDICAL MEETING CALENDAR

JANUARY

21-25—*Snowmass, CO;* **FOURTH ANNUAL CONFERENCE ON PAIN: THE PATIENT WITH CHRONIC LOW BACK PAIN;** Category 1 credit; Contact: Ronald G. Havican, Center for Rehabilitation Medicine, Emory Univ. Sch. of Med., Atlanta 30322.

20-26—*Augusta;* **FAMILY PRACTICE SYMPOSIUM;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

25—*Atlanta;* **FIFTH ANNUAL INFECTIOUS DISEASES SEMINAR — ADVANCES 1980;** Category 1 credit; Contact: Department of Graduate and CME, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211, ext. 2346.

26—*Atlanta;* **BORDERLINE PERSONALITY DISORDERS;** Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, 3400 Peachtree Rd., N.E., Ste. 913, Atlanta 30326. PH: 404/266-2887.

29—*Chattanooga, TN;* **TRAUMA CIRCUIT COURSE;** Contact: Dennis K. Wentz, M.D., Director of Continuing Education, Univ. of Tenn. Center for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

30-Feb. 1—*Atlanta;* **DIABETES IN REVIEW: CLINICAL CONFERENCE 1980;** Category 1 credit; Contact: Harry Hansen, American Diabetes Assoc., 600 Fifth Ave., New York, NY 10020.

FEBRUARY

7—*Chattanooga, TN;* **MEDICINE REVIEW: PULMONARY DISEASES;** Contact: Dennis K. Wentz, M.D., Director of Continuing Education, Univ. of Tenn. Center for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

7-8—*Augusta;* **PSYCHIATRY;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

7-12—*Atlanta;* **ANNUAL MEETING, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS;** Contact: Charles V. Heck, M.D., AAOS, 444 N. Michigan Ave., Chicago, IL 60611.

8-9—*Gainesville, FL;* **A SYMPOSIUM ON BURN CARE;** Category 1 credit; Contact: Bill Rockwood, Office of CME, Box J-233, J. Hillis Miller Health Center, Univ. of Fla. College of Med., Gainesville, FL 32610. PH: 904/392-3143.

14-15—*Chattanooga, TN;* **SOLVING PROBLEMS IN DRUG THERAPY;** Contact: Dennis K. Wentz, M.D., Director of Continuing Education, Univ. of Tenn. Center for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

16-20—*Atlanta;* **36TH ANNUAL MEETING, AMERICAN ACADEMY OF ALLERGY;** American Academy of Allergy, 611 E. Wells St., Milwaukee, WI 53202. PH: 414/272-6071.

21—*Chattanooga, TN;* **MEDICINE REVIEW: NEPHROLOGY;** Contact: Dennis K. Wentz, M.D., Director of Continuing Education, Univ. of Tenn. Center for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

21-22—*Atlanta;* **USING VIDEO TECHNOLOGY IN THE CLINICAL SETTING;** Category 1 credit; Contact: School of Medicine, Medical College of Georgia, Augusta 30912.

23—*Atlanta;* **NARCISSISTIC PERSONALITY DISORDERS;** Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, 3400 Peachtree Rd., N.E., 913, Atlanta 30326. PH: 404/266-2887.

23-24—*Augusta;* **MEETING, GEORGIA AND SOUTH CAROLINA SOCIETIES OF ANESTHESIOLOGISTS;** Contact: William T. Freeman, M.D., Medical College of Georgia, Augusta 30912. PH: 404/828-3871.

23-24—*Augusta;* **GASTROINTESTINAL ULTRASOUND;** Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

28-March 1—*Gainesville, FL;* **7TH ANNUAL SELECTED TOPICS IN UROLOGY;** Category 1 credit; Contact: Bill Rockwood, Office of CME, Box J-233, J. Hillis Miller Health Center, Univ. of Fla. College of Med., Gainesville, FL 32610. PH: 904/392-3143.

29-March 1—*Birmingham, AL;* **MKSAP: HEMATOLOGY, CARDIOVASCULAR DISEASES, PULMONARY DISEASES, NEPHROLOGY;** Contact: JoAnne Plummer, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

MARCH

1-8—*Steamboat Springs, CO;* **FIFTH ANNUAL SNOW JOB IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

2-9—*Caribbean Sea;* **ONCOLOGY IN GENERAL PRACTICE;** Category 1 credit; Contact: Peter W. A. Mansell, M.D., Clinical Cancer Education Program, Univ. of Miami Sch. of Med., Centre House, PH-E, 1400 N.W. 10th Ave., Miami, FL 33136. PH: 305/547-6103.

4-7—*Durango, CO;* **EMERGENCY MEDICINE: THE ADULT AND THE CHILD;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

6-7—*Atlanta;* **RECENT ADVANCES IN THE MANAGEMENT OF THE LONG TERM DIALYSIS PATIENT;** Category 1 credit; Contact: Associate Dean of CME, Emory Univ. Sch. of Med., 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

13-14—*Chattanooga, TN;* **CURRENT CONCEPTS IN THE MANAGEMENT OF BURNS;** Contact: Dennis K. Wentz, M.D., Director of Continuing Education, Univ. of Tenn. Center for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

16-19—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 credit; Contact: Winnie Hopkins, Medical Association of Atlanta, 875 W. Peachtree St., N.W., Atlanta 30309. PH: 404/881-6128.

20-22—*Gainesville, FL;* **11TH ANNUAL TOPICS IN INTERNAL MEDICINE;** Category 1 credit; Contact: Bill Rockwood, Office of CME, Box J-233, J. Hillis Miller Health Center, Univ. of Fla. College of Med., Gainesville, FL 32610. PH: 904/392-3143.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.


STATE OF GEORGIA
CONSTITUTION
WIS
DOM
JUSTICE
MODER
ATION
1776

JOURNAL
of the medical association of
georgia

The 1980 Georgia General Assembly — Who Will Represent Medicine?

JAMES A. KAUFMANN, M.D., and RUSTY KIDD, *Atlanta

Dear Brother Physician:

I am lonesome because I miss the company of my brother physicians at many gatherings, both civic and political, that I have attended over the past 20 years.

I am lonesome because I recently attended a reception for Congressman Doug Barnard, who has been a staunch and loyal friend of good health care, and I was the only physician present. He was one of only 75 members of Congress who voted against the monstrous hospital cost containment bill, but this apparently did not encourage physicians to honor him.

I am lonesome because I also recently attended a testimonial to Governor George Busbee, and I was the only Medical Association of Georgia member present. I would have liked to have had my brother physicians there.

I attended a Georgia Republican Day honoring Ambassador George Bush before he was a candidate, and I was the only medical doctor present. At a gathering of over 1000 for Ronald Reagan, there were three Georgia physicians. For President Carter, there were also three Georgia physicians out of over 1000.

I also have a feeling of loneliness when Governor Busbee and members of the State Senate and State House of Representatives approach me constantly as to why my colleagues do not join me in tramping the halls of the legislature to make their wishes known when numerous other health groups are present in great number. Members of Congress ask me all to frequently when I present the view of medicine on behalf of the Medical Association of Georgia why they do not hear from the other medical doctors back home. So, I am also a lonesome letter writer and telephoner.

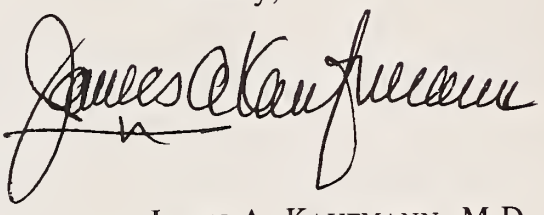
I could go on *ad infinitum* about events over the last 20 years, and I continue to be appalled by the lack of involvement and apathy of physicians in the political process that controls their lives and the civic events that contribute to their lives. However, even at this late hour, it is not too late to cure my loneliness and save something of society as we know it and contribute to the betterment of mankind. Each and every one of you, if you gave it a trial (and we would be glad to help) would be amazed at how enjoyable, rewarding, and far-reaching your involvement would be. Many criticize the American political process. Comparatively, it is the best process in the world. The only way this process can further deteriorate is with your continued lack of involvement.

* Dr. Kaufmann is Chairman of MAG's Committee on Legislation. His address is 950 W. Peachtree St., NW, Atlanta, GA 30309. Mr. Kidd is Director of Legislative Activities for the MAG. His address is 938 Peachtree St., NE, Atlanta, GA 30309.

Please join this lonely Medical Association of Georgia member — call, write, or wire today. You will be glad you did.

With every good wish, I am

Sincerely,



JAMES A. KAUFMANN, M.D.

Before you *can* join in the legislative action effectively and not only assuage Dr. Kaufmann's loneliness but also enhance your own political effectiveness, become familiar with the current issues and upcoming legislation that relate to the practice of medicine. To that end, we offer this partial list of legislation pending before the 1980 Georgia General Assembly and a few others that are sure to be introduced in January. This list serves to highlight some of the bills. It is not complete. Use it as another point of reference to help you learn more about issues in the political arena that continue to impact on and influence the way you practice medicine.

HB 83 Mental Illness Insurance

This bill would require that all accident and sickness insurance policies be required to make available coverage for the treatment of mental disorders, which is at least as extensive and provides at least the same degree of coverage as that policy or contract for the treatment of other types of physical illnesses. **MAG supports.**

HB 122 Voluntary Sterilization Act

The current proposal of the Senate Special Judiciary Committee requires that a request in writing be made prior to the sterilization procedure, and "in non-emergency or elective situations, [that] thirty days have elapsed from the time of the written consent before performance of the sterilization procedure." **MAG opposes.**

HB 139 Catastrophic Health Care Costs

The concept of HB 139 is to assure the availability of health insurance coverage for eligible expenses which exceed a catastrophic threshold in any 1 year to residents of this state. This would provide a means for state residents to protect themselves against the extraordinary cost of serious illness or injury and would provide a system insuring the availability of such protection to persons unable to purchase such insurance protection, either on an individual or group basis, directly from an insurance carrier. With enactment of state laws of this type there will be no need for National Health Insurance. **MAG supports.**

HB 228 Chiropractic Insurance

HB 228 would require all group and blanket insurance policies of accident and sickness insurance to provide coverage for services which are within the lawful scope of practice of a duly-licensed chiropractor in this state. Reimbursement will be for such services under such policies or contracts regardless of whether they are rendered by a duly-licensed doctor of medicine or a duly-licensed chiropractor. **MAG opposes.**

HB 553 Immunity — Peer Review Protection

This would provide protection for those individuals who are members of peer review groups which evaluate quality, efficiency, and professional health care providers and would protect the confidentiality of their records. **MAG supports.**

HB 599 Canadian Medical Graduates

The Conference Committee report waived the 1-year Georgia residency requirements for those persons who had graduated from accredited Canadian medical schools. This waiver would enable the Composite State Board of Medical Examiners to grant a medical license to those persons who have graduated from approved and accredited Canadian medical schools. **MAG supports.**

HB 652 Definition of Physician

HB 652 would restrict the word "physician" to refer to only those persons licensed under Georgia Code Chapter 84-9, the Medical Practice Act, or MDs and osteopaths. **MAG initiated and supports.**

HB 885 Fifth Pathway Program

This bill would extend from 3 years to 6 years the requirement that the Medical College of Georgia develop and offer a clinical training program for the purpose of accepting students from foreign medical schools. **MAG opposes.**

HB 1044 Commissioner, Department of Human Resources

This bill would amend the Executive Reorganization Act of 1972 to require the Commissioner of Human Resources to be elected by the people of Georgia in the same manner and at the same time as the elected constitutional executive officers of this state. This would be a 4-year term of office prior to re-election.

HR 90 Birth Defects — Responsibility

HR 90 states that a physician could be held liable for damages if a child is born deformed or with birth defects, if the physician had not disclosed to the prospective parents the likelihood or possibility that said child conceived by them may be born in a deformed condition or with birth defects. **MAG opposes.**

SB 11 Spinal-Cord Disabled Persons

This bill would require all physicians and others to notify the Department of Human Resources of all persons who are spinal-cord disabled. Spinal-cord disabled means any spinal cord disease, injury, or neural tube defect, whether congenital or acquired, which results in partial or total loss of motor or sensory functions and which results in partial or total disability whether such disability is temporary or permanent.

SB 44 Optometric Use of Drugs

Bill would permit optometrists in this state to use pharmaceutical agents for diagnostic purposes in the practice of optometry. **MAG opposes.**

SB 86 Life-Sustaining Procedures

This would provide Georgians with an opportunity to initiate a "Directive to Physicians" indicating their desire for the physician not to employ or to remove life-sustaining measures under certain conditions. **MAG supports.**

SB 95 Clinical Social Work Practice Act

This would create a new board for the licensure and regulation for the practice of clinical social work. "Clinical Social Work" is a professional service distinguished by its traditional focus on personal strengths, personal relationships, and the interaction of the individual with his or her environment. It is not dictated by professional setting but rather is a body of knowledge developed to effect change in human behavior, emotional responses, and social conditions of individuals, couples, families, groups, organizations, and communities.

SB 169 Psychology Insurance

This would require each insurance company which offers accident and sickness insurance in this state, and provides major medical insurance coverage, to affirmatively offer in such major medical insurance policies coverage for those services which an applied psychologist is authorized to render. **MAG opposes.**

SB 217 In-Patient/Out-Patient Insurance

The concept of SB 217 would require insurance companies to reimburse for medical procedures performed on an out-patient to the same degree as said medical procedures are performed on an in-patient. **MAG supports.**

Certificate of Need (CoN)

The 1979 General Assembly passed a CoN law. (See the December 1979 *Journal* for a more definitive discussion of this law.) This law specifically excluded physicians and dentists, both in their office locale and equipment purchases, although numerous attempts were made by the Hospital Association to include physician's offices.

There will be a bill introduced in the 1980 legislature to **repeal** the 1979 CoN law. **MAG supports.**

Authorization of Prescriptions

This is a bill stating that before the agent of a practitioner, licensed to prescribe drugs, can communicate an order for a drug, they must first be in direct communication with the practitioner regarding that particular prescription order.

Institutional Medical Licenses

There will be legislation in 1980 to require all persons who have an institutional license to practice medicine for less than 5 years to pass the FLEX exam within 3 years. Failure to do so results in revocation of their institutional license. There will be a "grandfather" clause exempting those who have had this license for 5 years. **MAG supports.**

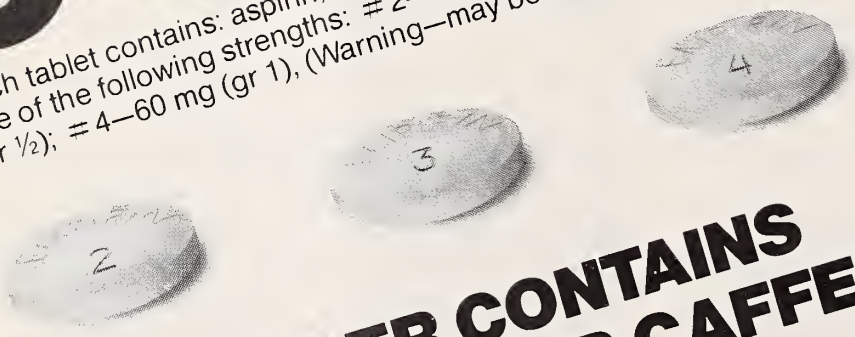
Coroner System

There will be legislation in 1980 generated by the House Health and Ecology Committee to begin a revamping and a reclassification of the qualifications, duties, and responsibilities of the Coroner system in Georgia. The MAG's interest obviously is in the area of medical examiner duties which is now under the jurisdiction of the county coroner. **MAG supports.**

EMPIRIN® COMPOUND ℂ CODEINE IS NOW EMPIRIN® ℂ CODEINE



Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg (gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)



NO LONGER CONTAINS PHENACETIN OR CAFFEINE.

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Surgery has been more successful in patients found to have anomalous conduction pathways through the left or right ventricular free walls than in those with septal connections.

Electrophysiological Diagnosis and Surgical Treatment of Recurrent Supraventricular Tachycardias Due to Wolff-Parkinson-White Syndrome

JOSEPH W. RUBIN, M.D., JOHN P. BOINEAU, M.D., and ROBERT STENSON JR., *Augusta**

Introduction

PAROXYSMAL SUPRAVENTRICULAR tachycardias (PSVT) associated with the Wolff-Parkinson-White (WPW) syndrome are often refractory to antiarrhythmic agents and cardiac glycosides. These arrhythmias may cause sudden death or markedly disable patients because of syncope.[1]

Description of the Wolff-Parkinson-White (WPW) Syndrome

The WPW syndrome is characterized by electrocardiographic abnormalities consisting of a short PR interval (0.12 second or less), normal or prolonged QRS complexes (0.11 second or more) with delta waves, and frequent occurrences of PSVT.[2] The general assumption is that the ventricular preexcitations are by accessory atrioventricular conduction pathways (AP) which bypass the normal conduction system. WPW may demonstrate two distinct electrocardiographic types but may not always conform strictly to either one. In type A, the delta wave is directed anteriorly and lead V-1 shows R, RS, and Rs patterns, whereas leads V-5 and V-6 show Rs or R deflections. Generally type A WPW syndrome resembles right bundle branch block, right ventricular hypertrophy, and posterior myocardial infarction. In Type A, premature activation via an accessory Kent bundle connection occurs in the left ventricle.[3, 4]

In contrast, the delta wave in type B is directed leftward and/or posteriorly, and the deep S wave in V-1 is ascribed to an anterior connection between the right atrium and right ventricle.[4] The standard and augmented leads 1 and aVL and precordial leads V-4 through V-6 show tall positive R waves with delta waves, whereas leads V-1 and V-2 show negative QRS complexes with delta waves. The electrocardiographic findings in type B WPW syndrome may closely resemble left bundle branch block and left ventricular hypertrophy. At times, the appearance of an antero-septal myocardial infarction pattern is produced in the type B WPW syndrome. In addition to left (type A) and right (type B) delineation of preexcitation, it is now possible to predict the site of an AP in either annulus within 1-2 cm by analysis of the 12 lead electrocardiogram.[5, 6]

Another syndrome associated with rapid atrial tachyarrythmias is the Lown-Ganong-Levine (LGL) syndrome. LGL, a facsimile of WPW, differs only in its absence of a delta wave. The characteristics of short PR interval, potentially abnormal QRS complexes and PSVT still exist in this less prevalent syndrome. A high degree of caution must be exercised while interpreting electrocardiograms for possible pre-excitation syndromes because of the therapeutic implications.[7]

* Dr. Rubin is Associate Professor of Surgery, Section of Thoracic and Cardiac Surgery, Medical College of Georgia (MCG), Augusta, GA 30912. Dr. Boineau is Professor of Medicine Section of Cardiology, MCG. This work is supported in part by USPHS NIH Grant HL 18398, a VA grant, and a grant from the Georgia Heart Association. Mr. Stenson is from the Student Education Enrichment Programs, MCG School of Medicine. Direct reprint requests to Dr. Rubin at the above address.

Incidence of WPW Syndrome

The first clinically comprehensive description of the syndrome was published by Wolff, Parkinson, and White in 1930 with a review of 11 cases.[8] Prior to this, there had appeared in the literature five scattered case reports with characteristic electrocardiographic findings. These characteristics were described by Wilson in 1915 and Wedd in 1921.[9, 10] The tachyarrhythmias may occur at any time from birth into adult life. The majority of WPW syndromes have been encountered in healthy people without organic heart disease. It has been estimated that the incidence of WPW is between 0.1 to 0.2% of the United States population. However, preexcitation is commonly seen in certain types of developmental heart disease, such as Ebstein's malformation and hypertrophic obstructive cardiomyopathy. The syndrome is more prevalent in males.[11] The electrocardiographic finding of WPW often mimics diaphragmatic myocardial infarction, and may be interpreted as such in daily practice. The most important diagnostic criterion is recognition of a delta wave; the short PR interval or prolonged QRS complex may not be present in every case. Diagnosis of WPW syndrome may be confirmed by a clinical (His bundle) electrophysiological study. In this procedure, the H-V interval is shorter than normal. The His bundle potential may occur simultaneously with the ventricular deflection, or the His bundle potential may occur after the onset of ventricular deflection.[12] Additionally, by recording endocardial potentials (endocardial mapping), further information on the site of pre-excitation and location of the AP can be obtained. Also, the effective refractory period (ERP) of the AP and AV node (AVN) can be determined. A short AP-ERP can be associated with an extremely rapid ventricular rate during atrial flutter or fibrillation.

Methods of Treatment

In most patients, the initial drug or choice for the treatment of PSVT is propranolol. Cardiac glycosides may also be effective in paroxysmal atrial tachycardia (PAT). For atrial fibrillation or flutter with anomalous conduction, intravenously administered lidocaine may depress the AP.[7] Procainamide or quinidine may result in arrhythmia control by lengthening the effective refractory period of the AP.[13] Digitalis preparations should not be used empirically in patients with atrial fibrillation or flutter or in patients with syncope, because it may shorten the AP-ERP and increase the heart rate.

Artificial cardiac pacemakers have been used to treat drug-resistent PSVT associated with WPW syndrome. The interruption of the re-entry cycle of the tachycardia by pacing stimuli is the fundamental mechanism responsible for the termination of PSVT. An appropriately timed pacemaker-induced atrial or ventricular impulse may block the re-entry cycle either in the AVN or the AP, so that the atria or ventricles become refractory to the re-entrant impulse.[14] Artificial pacing is most effective when the pacing electrodes are close to the AP.[15] Artificial pacing to terminate PSVT can be self-initiated by a radiofrequency activated pacemaker in certain patients. A drawback of artificial pacing by a radiofrequency device is the potential for development of atrial fibrillation when the rate of discharge is sufficiently high. It has been recommended that radiofrequency pacemakers be used only when the refractory properties of the anomalous pathway are confidently known.[16] Of historical interest now is intentional destruction of the AVN with implantation of an artificial ventricular pacemaker for the treatment of refractory PSVT.[17]

The combined electrophysiological and surgical approach to the treatment of PSVT is considered in selected patients who suffer recurrent episodes which cause syncope, angina pectoris, severe dyspnea, or profound weakness refractory to antiarrhythmic drugs.[18] To date, only a small number of patients have undergone successful surgical treatment. Sealy and co-workers have accumulated the largest surgical group. Surgery has been more successful in patients found to have anomalous conduction pathways through the left or right ventricular free walls than in those with septal connections. Surgical interruption depends upon electrophysiological mapping of the activation sequence of the heart.[6, 19] Epicardial mapping is performed by recording and measuring local electrograms and activation times at multiple epicardial sites and locating the point(s) of earliest epicardial pre-excitation. In addition, epicardial atrial mapping is also performed during PAT and ventricular pacing to identify the site of atrial pre-excitation during PAT. The earliest pre-excited atrial and ventricular sites should correspond. The anomalous conduction tracts are then assumed to cross the atrioventricular groove at the point(s) of earliest abnormal pre-excitation. The tracts are divided by separating atrial and ventricular attachments at the point(s) of pre-excitation above the mitral or tricuspid annulus.

Case Report

The following case report illustrates the electrophysiological diagnosis and surgical approach to the treatment of refractory PSVT due to WPW performed at the Medical College of Georgia.

D.B., a 34-year-old male, gave a history of repeated episodes of rapid palpitation lasting up to 1 hour. Although he had experienced these episodes for approximately 20 years, he complained more recently of associated dyspnea, chest pain, nausea,

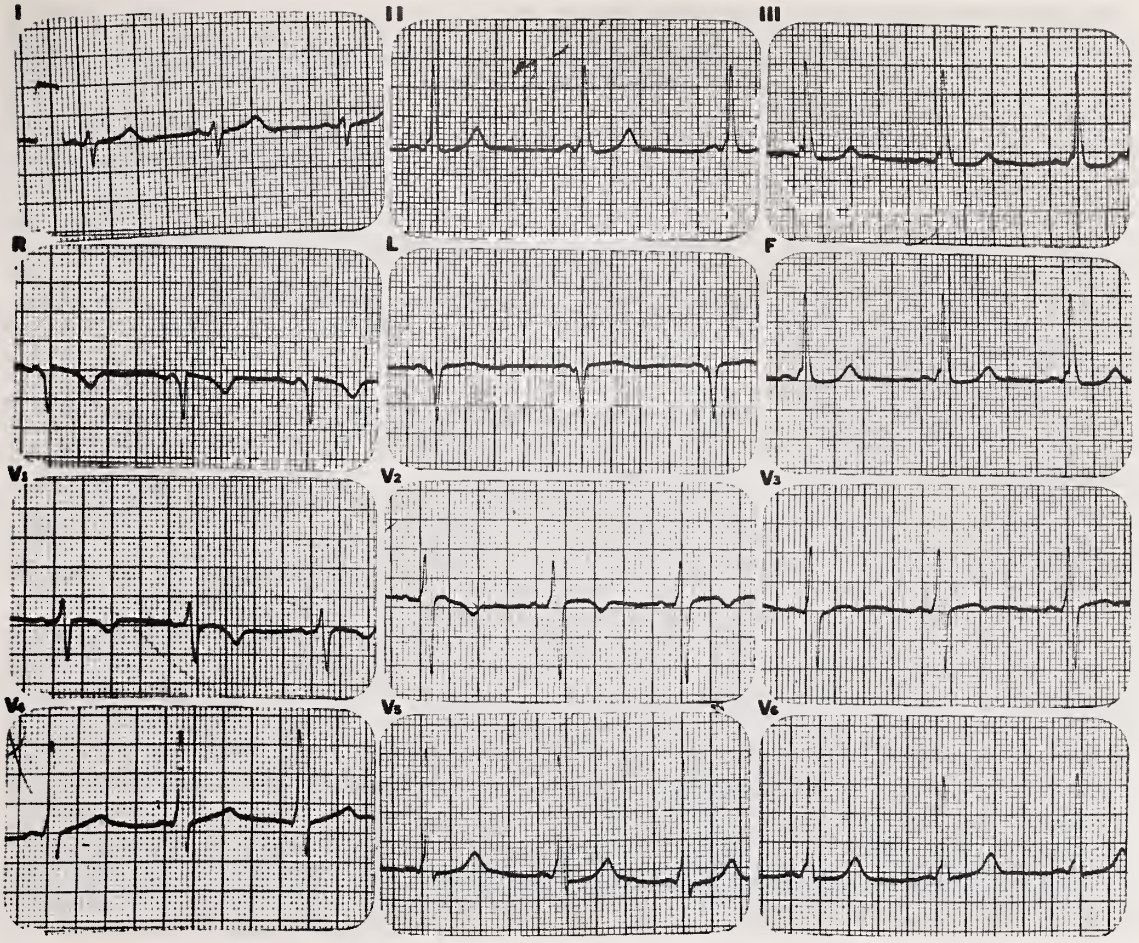


Figure 1 — A preoperative electrocardiogram compatible with WPW syndrome with antero-lateral left ventricular pre-excitation.

and vomiting. At least one episode was accompanied by syncope, and frequently his pulse would exceed 200 beats per minute. On admission, he had an electrocardiogram compatible with WPW syndrome with anterolateral left ventricular pre-excitation (Figure 1). Physical examination was normal and indicated a well-nourished, apparently healthy, robust male. Multiple pharmacologic attempts by his local physician to control the episodes of PSVT had failed. He had received quinidine, propranolol, digitalis, and several other anti-arrhythmic agents alone or in combination without altering the frequency of his episodes.

He underwent cardiac catheterization which demonstrated normal hemodynamics and normal coronary arteries. A clinical electrophysiological study was performed and endocardial recordings indicated a left-sided AP. Premature stimulation and rapid pacing of the atria reproduced PAT, with ventricular rates in excess of 200. Because of his recent history and failure to control the bouts of PSVT pharmacologically, surgical interruption of the AP was recommended and accepted by the patient.

The heart was exposed through a standard midline sternal incision. A net containing 48 electrodes was wrapped around all of the exposed ventricular surfaces. Potentials recorded from the multiple electrodes were processed by a computer to obtain activation sequence maps. Left atrial pacing consistently revealed a region of pre-excitation immediately anterior to the obtuse marginal coronary artery just below the mitral annulus. PSVT was reproduced consistently by rapid atrial stimulation. Atrial mapping during repetitively evoked bouts of PAT revealed pre-excitation of the left atrium immediately above the area of ventricular pre-excitation.

The patient was placed on extra-corporeal circulation, and core-cooled to 26°C. The heart was arrested with infusion of 300 ml/m² of potassium cardioplegia at 10°C into the aortic root. The left atrium was opened laterally revealing a normal chamber and mitral valve mechanism. The left atrial wall was incised 2 mm above the mitral annulus from the left anterior fibrous trigone posteriorly to the posteromedial mitral commissure. By blunt and sharp dissection, all the filamentous attachments between atrium and ventricle beneath the circumflex coronary vessels were separated. After the incision above the mitral annulus was sutured, the atrial chamber was closed and carefully deaired. The patient was warmed and separated from extracorporeal circulation without difficulty.

Postoperative mapping of the epicardium demonstrated the area of pre-excitation to be no longer

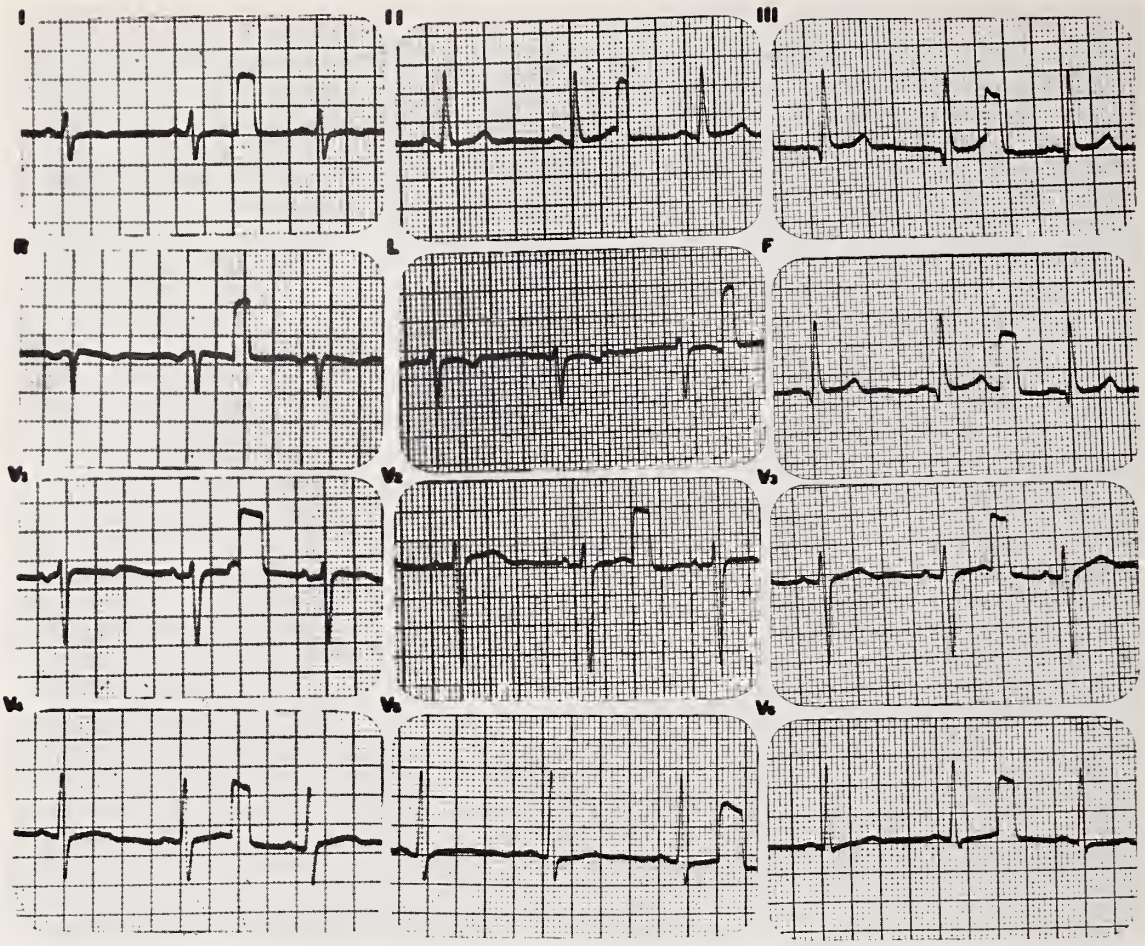


Figure 2 — Three month postoperative electrocardiogram is normal after selective division of an AP which was located immediately anterior to the origin of the obtuse marginal coronary artery.

present, and PSVT could not be induced. Recovery was uneventful, and the patient was discharged on the 8th postoperative day.

Three months after surgery, the electrocardiogram was normal (Figure 2), and repeat electrophysiological studies with both premature and rapid atrial stimulation failed to reproduce any PSVT. He did not suffer any further episodes and was advised to resume normal activities and work. Postoperative electrocardiograms demonstrate absence of pre-excitation.

Acknowledgements

The authors wish to thank Dr. Ronnie R. Smith from Vidalia, Georgia, for referring this patient to us. We also appreciate the assistance of Ms. Anita Wylds and Messrs. Charles Brockus and Carey Miller for processing the electrograms. Ms. Mary Seldin prepared the manuscript.

References

1. Cobb FR, Blumenschein SD, Sealy WC, et al.: Successful surgical interruption of the bundle of Kent in a patient with the Wolff-Parkinson-White syndrome. Arch Intern Med 1975; 135:422.

2. Durrer D, Roos JP: Epicardial excitation of the ventricles in a patient with Wolff-Parkinson-White syndrome (Type B). Circulation 1976; 35:15.

3. Boineau JP, Moore EN: Evidence for propagation of actuation in types A & B pre-excitation. Circulation 1970; 41:375.

4. Mann RB, Fisher RS, Schertis S, Hutchins GM: Accessory left atrioventricular connection in type A Wolff-Parkinson-White syndrome. Johns Hopkins Med J 1973; 132:242.

5. Boineau JP, Moore NE, Sealy WC, Kasell JH: Epicardial mapping in Wolff-Parkinson-White syndrome. Arch Intern Med 1975; 135:422.

6. Gallagher JJ, Gilbert M, Svenson RH, et al.: Wolff-Parkinson-White syndrome: the problem, evaluation and surgical treatment. Circulation 1975; 51:767.

7. Wellens HJJ: Effects of drugs on Wolff-Parkinson-White syndrome. *His Bundle Electrocardiography and Clinical Electrophysiology*, Narula O (ed), Philadelphia: F. A. Davis Co., 1975.

8. Prinzmetal M, Kennamer R, Corday E, Osborne JA, Fields J, Smith LA (eds): The Wolff-Parkinson-White syndrome and related conditions. New York: Grune and Stratton, 1952, p. 3.

9. Wedd AM: Paroxysmal tachycardia, with reference to normotropic tachycardia and the role of the extrinsic cardiac nerves. Arch Intern Med 1921; 27:57

10. Wilson FN: A case in which the vagus influences the form of two ventricular complexes of the electrocardiogram. Arch Intern Med 1915; 10:1008.

11. Chung EK, Walsh TJ, Magsie E: Wolff-Parkinson-White syndrome. Am Heart J 1965; 69:116.

12. Massumi RA, Vera Z, Mason DT: The Wolff-Parkinson-White syndrome. Mod Conc Cardiovasc Dis 1973; 42:41.

13. Mark H, Luna LS: Treatment of Wolff-Parkinson-White syndrome. Am Heart J 1975; 90:744.

14. Barold SS, Linhart JS: Recent advances in the treatment of ectopic tachycardias by electrical pacing. Am J Cardiol 1970; 15:698.

15. Gallagher JJ, Svenson RH, Sealy WC, et al.: Wolff-Parkinson-White syndrome and the pre-excitation dysrhythmias, medical and surgical management. *Symposium on Cardiac Rhythm Disturbances,* Resnekov L (ed), Med Clin North Am 1976; 60:101.

16. Tonkin AM, Gallagher JJ, Wallace AG: Tachyarrhythmias in Wolff-Parkinson-White syndrome, treatment and prevention. JAMA 1976; 235:947.

17. Edmonds JH, Ellison RG, Crews TL: Surgically induced A-V block as a treatment for recurrent atrial tachycardia in Wolff-Parkinson-White syndrome. Circulation 1969; 40(suppl I):105.

18. Sealy WC, Wallace AG: Surgical treatment of Wolff-Parkinson-White syndrome. J Thorac Cardiovasc Surg 1974; 685:757.

19. Sealy WC, Gallagher JJ, Pritchett ELC: The surgical anatomy of Kent bundle based on electrophysiological mapping and surgical exploration. J Thorac Cardiovasc Surg 1978; 76:804.

Post-Mortem Tragedies

D.O.A. That's what the nurse had said. You glance at the glowing digits on the face of your alarm clock; 3:15. Your hand touches the telephone again, briefly. It's secure in the cradle. The stillness of the house is familiar, reassuring. The ringing call had not disturbed the other members of your sleeping family.

Now, you remember. Bruce was about twenty-six-or-seven and his wife was three or four years younger. What a tragedy. A truck ran a stop sign and the lives of two young people came to a crashing end. What bitter irony. You saw them just last month, for complete examinations. They were worrying that maybe they couldn't have children. You wonder if they'd planned to have the fertility tests you had suggested. Maybe she was pregnant. You anticipate the melancholy ritual of reviewing their records and completing the death certificates. Wondering where their parents live, your anguish lingers until sleep returns.

You are reminded that you meant to look at their charts when you hear the details of the accident that took the lives of Bruce and Debbie Brown as described on the late-night television news the following evening. The next day you take a few minutes of your lunch time to get their charts from your files and write "Deceased" across the name tab. You review the information you have recorded over the years. You add a brief note to each record describing the date, hour and violent circumstances of the deaths. Later, you complete the death certificates, sign them, have some copies made and see that they are mailed. In your mind and heart, the tragedy has ended although, in fact, it has not.

How could you know that four blind persons were robbed of their precious inheritance of sight from Bruce and Debbie Brown? You hadn't asked either of those young, healthy adults if they had willed their eyes to the living.

How could you know that four despairing uremic patients will stay on the dialysis program because they did not receive the kidneys which had been willed to them by Bruce and Debbie?

How could you know that two victims of intractable heart disease will drown with pulmonary edema much sooner because two young and healthy hearts, promised to living, hoping people were embalmed and buried with dead bodies?

How *could* you know? Simply by making it part of the knowledge you obtain from every one of your patients. Ask them, without fail, if they have willed their eyes or kidneys or hearts or bodies to an organization or institution. If they have, record the details of their thoughtfulness and the fact of their posthumous gifts where it will not be overlooked. Encourage them to carry the information with their personal identification cards; suggest that they add the words "Organ Donor" or "Anatomical Assignments" to medical information tags, bracelets and other such devices. Also, make it policy to mark their records in some conspicuous way so that even a casual inspection will disclose this vital information. Printing the words "Organ Donor" or "Anatomical Assignments" on the inside of the front of the chart folder, in bold, red letters will help prevent many unfortunate oversights. Writing the same words on the order sheet of a hospital record can also reduce the incidence of these post-mortem tragedies.

Knowledge of anatomical assignments is important enough to be considered part of every patient's vital statistics. We must make it a part of every medical history. It is part of our obligation to our patients, our profession and our society.

How *could* you *not* know?

(Reprinted from the September 1979 issue of the Journal of the Oklahoma State Medical Association *(OSMA). Written by Mark R. Johnson, M.D., Editor-in-Chief of the OSMA* Journal.)

Stanley H. KAPLAN
® EDUCATIONAL CENTER
TEST PREPARATION SPECIALISTS SINCE 1938

OUR 41st YEAR

Prepare for:

National Medical Boards
VQE•ECFMG•FLEX•TOEFL
Nursing Boards
National Dental Boards

- Stanley H. Kaplan has represented quality test preparation for 40 years. Word-of-mouth recommendations have helped us become the largest test preparation organization in the world with more than 80 centers in the United States and abroad. Our vast resources and experience provide an umbrella of testing know-how that assures you the best preparation possible.
- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.

Flexible Programs and Hours
Please come visit our center
2964 Peachtree Rd., N.W., Suite 654
Atlanta, Georgia 30305
404-262-7582
Centers in major U.S. cities, Puerto Rico, Toronto, Canada and Lugano, Switzerland

The Great CHEROKEE TRADING COMPANY ®

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS
RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

Serving the General Insurance needs of the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT ®

American Holistic Medical Association's
6th Scientific Program

HEALTHY LIFESTYLE:
ACHIEVING FULFILLMENT

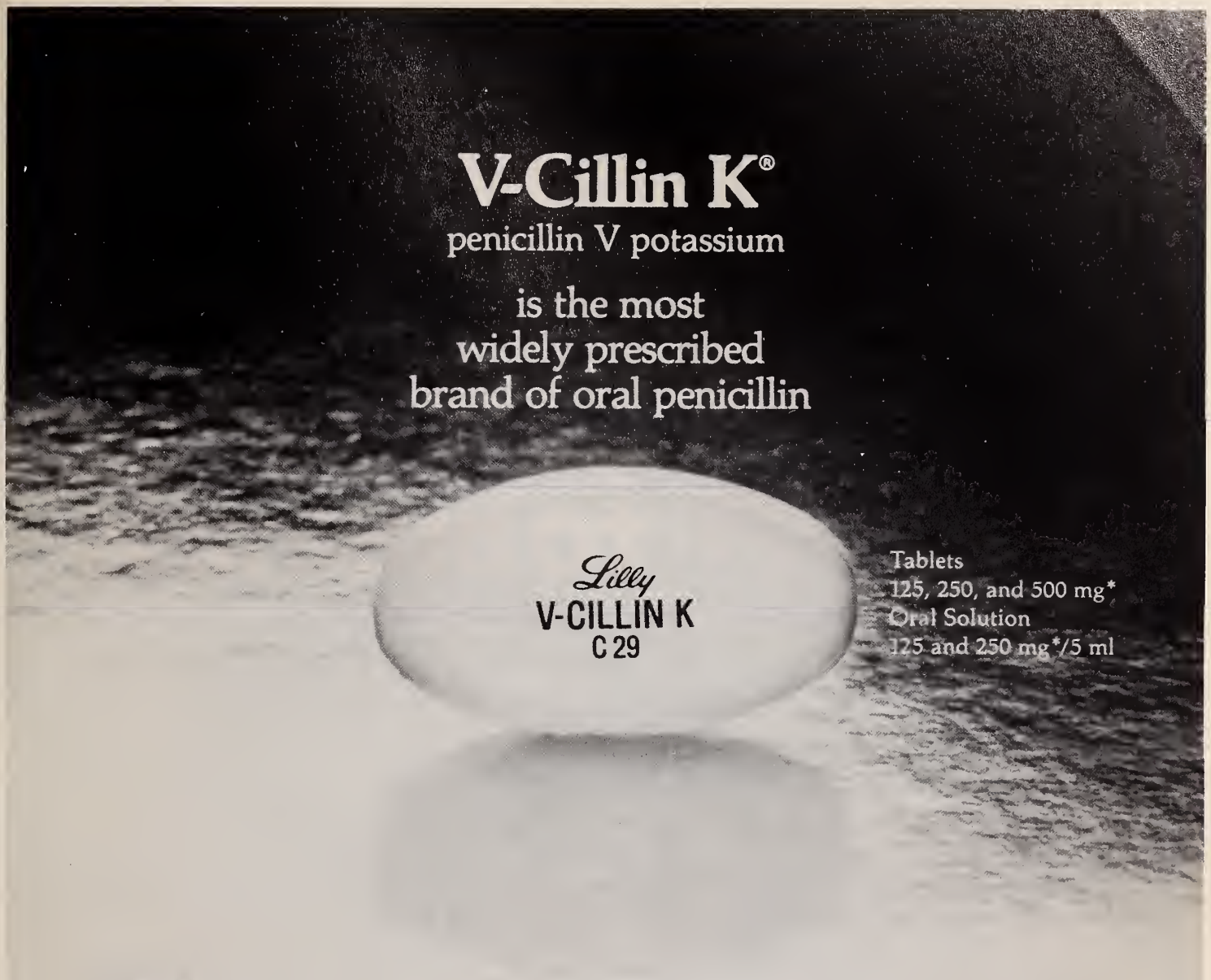
March 14-16, 1980
Sheraton Twin Towers
(5 minutes from Disneyworld)
Orlando, Florida

Keynoter: Joseph A. Pursch, M.D., Chief Alcohol Rehabilitation Service, Long Beach Naval Hospital

With Harold Bloomfield, M.D. Best selling author and twelve other authorities. Workshops and lectures; practical management of comprehensive medicine; avoiding burnout; financial security; acupuncture; physical conditioning; nutrition; biofeedback; drug management. Education and R & R.

13 hours of Category I CME

Contact: AHMA, Route 2, La Crosse, WI
(608) 786-2660



V-Cillin K*
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

900416


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action **Triavil**®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL—a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

Copyright © 1980 by Merck & Co., Inc.

by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

When the acute infection is acquired during pregnancy, it is transmitted to the fetus in approximately 40% of the cases. Forty percent of these, or 16% of the total, will have severe or fatal involvement.

Toxoplasmosis in Pregnancy: Clinical Viewpoint and Report of a Chronic Case in Pregnancy

WILLIAM C. TIPPINS JR., M.D., F.A.C.O.G., *Decatur**

With the advent of increased lay press interest in toxoplasmosis, there has been a tremendous increase in pregnant patients requesting that tests be done for the disease, especially in cat owners. The evidence of acute toxoplasmosis in pregnancy is rare, and fortunately, most physicians have seldom, if ever, delivered a baby with toxoplasmosis. A review of the records of obstetric deliveries at Georgia Baptist Hospital since 1971 reveals only one recorded case of congenital toxoplasmosis out of 17,437 deliveries. Yet other literature indicates that congenital infection occurs in one out of 500-1000 pregnancies.[1] A prospective study[2] done in Birmingham, Alabama, showed 1 in 500 infants were infected with this disease, and another study in New York City indicated that 1 in 1,300 newborns were infected.[3] Toxoplasmosis is not a reportable disease for the Georgia Department of Public Health, so the real incidence in this state may actually be greater than the Georgia Baptist Hospital records indicate.

It has been estimated that chronic asymptomatic toxoplasmosis infection exists in 50% of the population of the United States.[4] Toxoplasmosis is transmitted to the fetus of a pregnant patient only in patients who acquired the acute infection during pregnancy. Having the disease prior to pregnancy does not affect the fetus. When the acute infection is acquired during pregnancy, it is transmitted to the fetus in approximately 40% of the cases. Forty percent of these, or 16% of the total, will deliver severely deformed infants.[1, 3] These infants may have signs of microcephaly, hydrocephaly, seizures, mental retardation, hepatosplenomegaly, carditis, retinochoroiditis, and cerebral calcification.

It is important that laboratory tests for the disease be properly understood by the clinician, so that actual acute infection during pregnancy, which would warrant the consideration of a therapeutic abortion, is not confused with chronic disease, which would not warrant consideration of an abortion. The following case report illustrates this.

Case Report

A 29-year-old woman was seen on 3-14-79; she was approximately 6 weeks' pregnant. She had delivered a normal baby in 1966, miscarried in 1968, delivered a normal baby in 1969, and miscarried in 1974. A physical examination was within normal limits. Laboratory results showed a normal complete blood count, blood type B+, serology non-reactive, and rubella antibody titer 1:32. A Pap smear was negative. Because the patient owned several cats, she requested a test for toxoplasmosis.

The toxoplasma serology titer was reported as 1:512 by a commercial laboratory, with the notation that "titers higher than 1:256 were more likely to represent recent or active infection. Paired acute and convalescent titers showing a four-fold rise is considered significant." A repeat serologic test on 4-23-79 showed a titer of 1:1024.

At this point, the patient considered having an abortion. I saw her at this time and consulted with the Center for Disease Control (CDC) in Atlanta because of its extensive work with this disease.[5] An IgM assay was advised on blood previously drawn.

* Dr. Tippins is an obstetrician-gynecologist. His address is 5040 Snapfinger Woods Dr., Decatur, GA 30035.

Another blood specimen was drawn and sent to the CDC on 5-4-79. The commercial laboratory was requested to do IgM assay on samples they had and send the blood specimens to the CDC. IgM assays were reported as being negative by the commercial laboratory, and the CDC reported negative IgM, IgG of 1:64 (a low titer), and indirect hemagglutination titers of 1:256 on all blood specimens. As a result of these tests, it was felt that the patient had chronic toxoplasmosis, but was not acutely infected during this pregnancy. A therapeutic abortion, therefore, was not indicated. The patient subsequently delivered a healthy baby.

Etiology

Toxoplasmosis infection is acquired through eating raw or poorly cooked meat or raw, unwashed fruit or vegetables containing the cyst forms of the disease or from the oocysts discharged with cat feces. Members of the cat family are definitive hosts.[3, 4, 5] Symptoms in humans may appear 4 to 21 days[5] after the ingestion of contaminated meat.

In many cases, the symptoms of acute toxoplasmosis are mild; the patient may be asymptomatic. Symptoms include fever, headache, stiff neck, myalgia, rash, and lymphadenopathy, with the cervical nodes being most commonly involved. Asymptomatic localized lymphadenopathy may be seen without the other symptoms. Chorioretinitis may be seen as the sole manifestation.[4, 5, 6] Symptoms may resemble those in infectious mononucleosis and with a negative heterophile, toxoplasmosis should be suspected.

As stated before, the incidence of acute toxoplasmosis in pregnancy is low, and in the newborn, even lower. Of women in the childbearing age group (20 to 39 years) in this country, 25 to 40% have chronic toxoplasmosis. In my 22-year experience as an obstetrician, I have seen only one case of acute toxoplasmosis in pregnancy. This was in a patient in the third trimester who delivered a living nonaffected baby.

Laboratory Tests

Serologic tests for specific toxoplasmosis antibodies are the primary method of diagnosis. IgG antibodies may be detected by indirect fluorescent antibody tests, indirect hemagglutination tests, Sabin-Feldman dye test, and complement fixation test. Paired titers showing a four-fold rise in titer (2 tube) using a two-fold dilution system is a significant rise and indicates acute infection.[3, 4] In chronic cases, the titers may remain elevated. An elevated titer alone does not necessarily indicate an acute case — just as, for example, a positive skin test for tuberculosis does not necessarily indicate active disease. An IgM titer appears early, usually peaks within a month, and usually reverts to negative within another few months. A single high titer or a serial two-tube rise in titer (when tubes are run in parallel) indicates acute disease.

Krick[4] states, "with the exception of a single high IgM indirect fluorescent-antibody titer or a serial two-tube rise in titers to high levels in any serologic test, no other serologic test result by itself establishes the diagnosis of acute infection. All other positive serologic test results may be seen in chronic asymptomatic infection. Even a conventional fluorescent-antibody or dye test titer as high as 1:4000 may persist for more than 1 year."

It should be noted that in a patient who is first tested in the second or third trimester and has a positive titer and negative IgM, one cannot rule out that acute infection may have occurred early in pregnancy. Amniocentesis is not considered of value in determining fetal infection.

Treatment

Treatment will depend primarily on the state of the pregnancy at the time. If the diagnosis of acute infection is made late in the pregnancy, there is no alternative but to continue the pregnancy. If the disease is acquired and diagnosed in the first or second trimester of pregnancy, however, a therapeutic abortion must be considered. The patient and her husband must be presented with the possible effects to the fetus and the statistical likelihood of their occurrence. Should the patient elect to continue the pregnancy, treatment should be started.

The treatment of toxoplasmosis in the adult is with sulfadiazine, pyrimethamine (Daraprim), and folinic acid (*not* folic acid). Doses consist of 4 gms. sulfadiazine daily in divided doses for 28 days. Pyrimethamine in a loading dose of 75 mgs., is followed by daily single doses of 25 mgs. for 28 days, given concurrently with the sulfadiazine. Folinic acid is given intramuscularly 6 mgs. 3 times a week. Due to the possible teratogenic effects of pyrimethamine, sulfadiazine should be used alone in the first trimester of pregnancy.[1, 3, 4, 6]

Prevention

Since the main source of toxoplasmosis is uncooked or poorly cooked contaminated meat, contaminated fruits and vegetables, and cat feces, pregnant women should be advised to eat meat which is well cooked, avoid cat feces (that is, litter boxes, sand boxes, etc.), and be sure fruits and vegetables are washed.

Serologic tests for toxoplasmosis done prior to pregnancy are advantageous as an indication that the patient is not at risk for transmission of the infection to the fetus in a future pregnancy. During pregnancy, the development of a positive titer in a patient with a previously negative test would be of definite significance. Routine testing for toxoplasmosis is not in general use at the present.

Summary

Due to the severe effects that may result to the fetus from acute maternal toxoplasmosis, the prevention, early and accurate diagnosis, and treatment of the disease are essential.

References

1. Jones TC: Toxoplasmosis. *Current Therapy*, Conn, H (ed), Philadelphia: Saunders, 1979, p. 73-74.
2. Kimball AC, Kean BH, Fuch F: Congenital toxoplasmosis: a prospective study of 4,048 obstetric patients. Am J Ob-Gyn 1971; 111:211-217.
3. Fuchs F, Kimball AC, Kean BH: The management of toxoplasmosis in pregnancy. Clincis in Perinatology 1974; 1:407-422.
4. Krick JA, Remington JS: Current concepts in parasitology. Toxoplasmosis in the adult — an overview. N Engl J Med 1978; 298:550-553.
5. Teutsch SM, Juranex DD, Sulzer A, Dubey JP, Sikes RK: Epidemic toxoplasmosis associated with cats. N Engl J Med 1979; 300:695-699.
6. Goldsmith RD: Toxoplasmosis. *Current Medical Diagnosis and Treatment*. Krupp MA, Cotton MJ, (ed). Los Altos, CA: Lange, 1979; p. 897-898.

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard



"An English or Irish doctorate cannot be obtained by a very young man, and it is reasonable to suppose, what is likewise by experience commonly found true, that he who is by age qualified to be a doctor, has in so much time gained learning sufficient not to disgrace the title, or wit sufficient not to desire it."

Samuel Johnson
Journey to the Western Islands of Scotland

Practice what we teach

Today there are over 31 million men, women and children suffering from the many forms of arthritis and related rheumatic diseases. And there just aren't enough trained rheumatologists to help them.

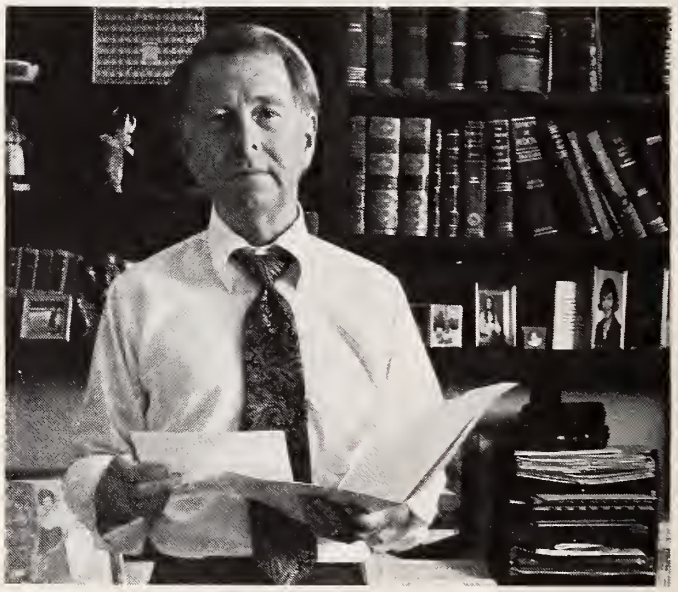
That's why arthritis sufferers need your help.

They must depend heavily on the family practitioner for better diagnosis, more effective patient treatment.

Contact your local Arthritis Foundation chapter for the latest information on arthritis. This includes continuing educational seminars by leading rheumatologists, scientific meetings, "outreach" programs—as well as the "Bulletin on the Rheumatic Diseases," "Arthritis and Rheumatism Journal," "Primer on the Rheumatic Diseases," audio cassettes and other professional materials. Free disease handbooks and medication pamphlets are also available to patients.

Please. Let us help your practice with what we teach.

The Arthritis Foundation helps doctors help.



ARTHRITIS FOUNDATION.

A public service of this magazine.

The author's operative technique and results of orbital decompression are described.

Orbital Decompression and the Treatment of Orbitopathy in Graves' Disease

CLINTON D. McCORD, M.D., F.A.C.S., *Atlanta**

Introduction

A SMALL BUT SIGNIFICANT percentage of patients with dysthyroid disease are affected with an infiltrative process in the orbit which can endanger vision and produce disfigurement.

This process occurs in a variety of states of thyroid activity but can commonly occur or accelerate following the treatment of a hyperactive thyroid gland. Evidence is accumulating that the orbital tissue is a victim of an autoimmune disease.[1] The orbitopathy is caused by infiltration of the extraocular muscles and orbital tissue with lymphocytes, plasma cells, and fibroblasts. Large quantities of mucopolysaccharides are produced with absorption of water. A marked increase in intraorbital volume and pressure is produced, and the extraocular muscles may swell from four to five times their normal size and compress the optic nerve at the orbital apex. Vision is impaired from exposure of the proptosed globe with corneal changes and/or compression of the optic nerve causing an ischemic neuropathy which may drastically reduce vision.[2, 3] The ischemic neuropathy may occur in some cases in the absence of severe proptosis when fibrotic muscles prevent the eye from being prolapsed forward and severe localized apical muscle swelling occurs.

Three modalities of treatment are available for this distressing situation. The neuropathy is responsive to high doses of steroids (100 mg. of prednisone per day or more) in 50% of the cases. The exact threshold of response dose is unknown; however, it is felt that patients who will respond will do so within 1 week, and those who do not should not be subjected to continued steroids.[3] Super voltage radiotherapy to the apex of the orbit has been useful in the neuropathy presumably by dissolving the infiltrates at the orbital apex. Four to six meV 1500-2000 RAD in divided doses is applied to the apex of the orbit with the linear accelerator and improves 65% of the patients.[4] Conventional radiotherapy has little or no effect. Excision of a portion of the orbital bone to allow the orbital contents to expand has been successful in a high percentage of cases in both improving the optic neuropathy and in relieving the proptosis, corneal exposure, and disfigurement. The success rate of this orbital decompression varies according to surgical technique, and many patients require supplemental radiotherapy.

The disadvantages of the use of systemic steroids are their well-known side effects and their minimal effect on the mechanical proptosis. The disadvantages of radiotherapy are post irradiation change in the orbit which may have long term consequences and which is felt to preclude subsequent orbital decompression if it is needed. The disadvantages of orbital decompression are the requirement of hospitalization, a surgical procedure, and general anesthesia, although the hospital course and postoperative period is usually a benign one.

Orbital Decompression

The relief of the severe orbital pressure in Graves' Disease has been treated surgically by removal of the

* Dr. McCord is Clinical Professor of Ophthalmology, Emory University School of Medicine. Send reprint requests to Dr. McCord at 2004 Peachtree Rd., NW, Atlanta, GA 30309.

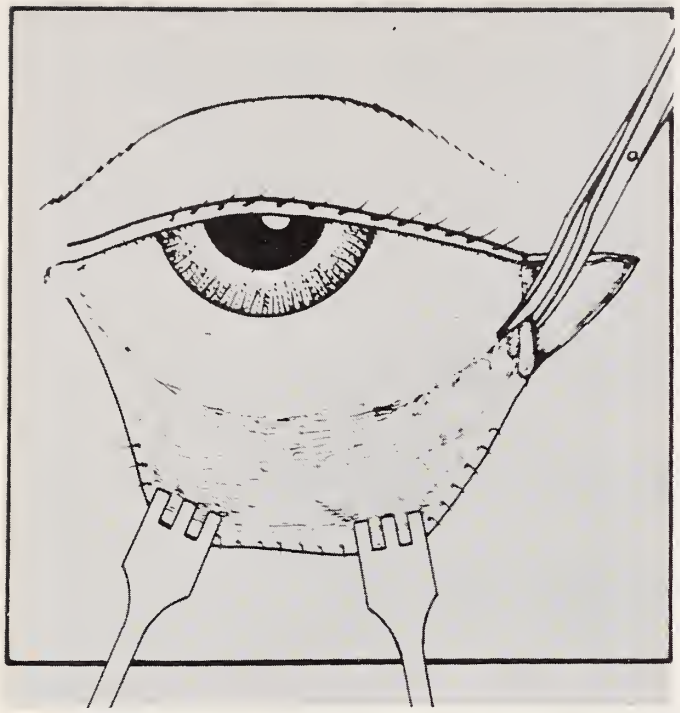


Figure 1 — Incision of lower limb of the lateral canthal tendon with fornix incision.

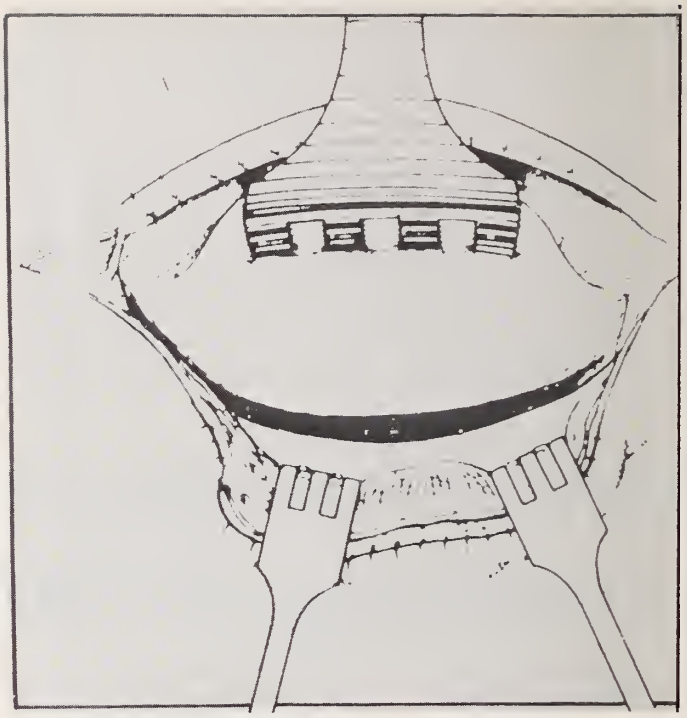


Figure 2 — Elevation of the periosteum from the floor of the orbit and ethmoidal area.

orbital roof through a craniotomy incision,[5] removal of the lateral wall,[6] removal of the orbital floor,[7] removal of the ethmoids,[8] removal of the greater wing of the sphenoid,[9] and combined removal of the floor of the orbit and the ethmoids.[10] Orbital decompression by removal of the orbital floor and ethmoids or antral-ethmoidal decompression (A-E decompression) is by far the most effective method and was popularized by Ogura[10] and others[11] through a transantral exposure. A-E decompression has also been performed with exposure through the eyelid[12, 13] and in many cases has been combined with a lateral wall excision.

Technique of Orbital Decompression

The technique and results of orbital decompression used by the author will be described.

Exposure of the orbital floor and ethmoidal area is obtained by performing a lateral cantholysis and severance of the lower limb of the lateral canthal tendon and rotating the lower lid outward so that an incision can be made in the lower fornix down to the periosteum (Figures 1-4). This is performed throughout the entire length of the inferior orbital rim up to the lacrimal sac area (Figure 1). The periosteum is then elevated from the orbital floor and the ethmoids (Figure 2), and the orbital floor and ethmoids are excised with direct visualization together with the sinus mucous membrane in that area. The ethmoids are excised up to the level of the anterior and posterior ethmoidal arteries. The infraorbital nerve may be spared in milder cases if desired

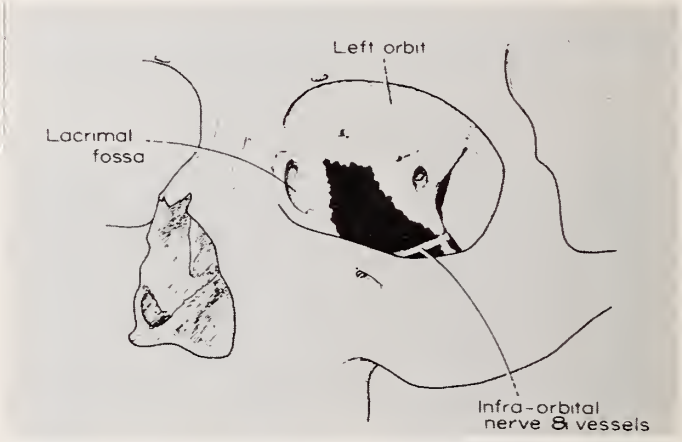


Figure 3 — Area of bone usually excised from floor of orbit and ethmoidal area.

(Figure 3); however, in more severe cases it may restrain decompression. To obtain the full effect of decompression, the periosteum of the orbital floor and the ethmoids are then excised, and different amounts can be excised in different patients to quantitate the desired effect (Figure 4). With this eyelid exposure, important structures such as the lacrimal sac and the inferior oblique muscle can be easily seen and protected. The lower fornix incision is then closed and the lateral canthal tendon reattached as seen in Figure 5. Figure 6 lists the advantages of exposure by this method. This method of exposure can be easily modified to combine the A-E decompression with a lateral decompression in the more severe cases to produce the greatest effect.

The effectiveness of orbital decompression can be measured by the amount of mechanical retroplace-

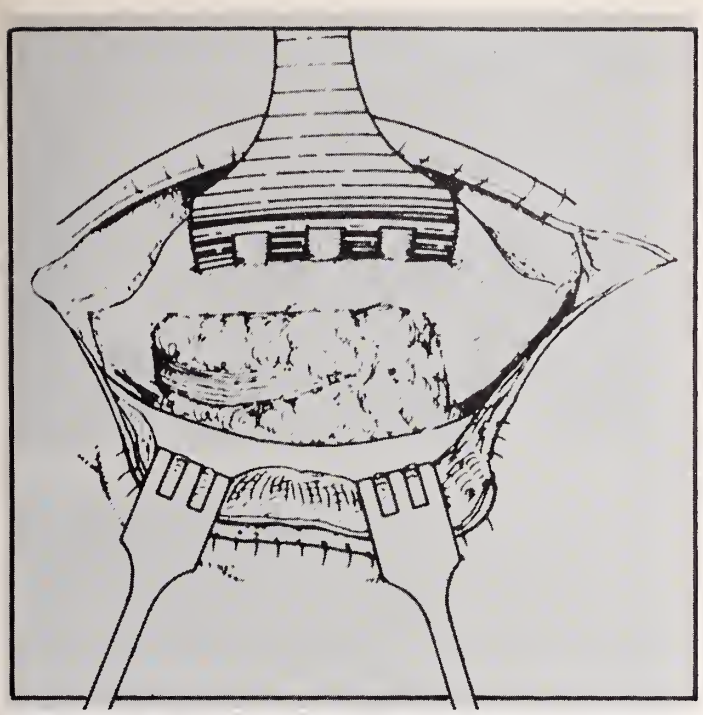


Figure 4 — Excision of orbital periosteum allowing prolapse of orbital flap.

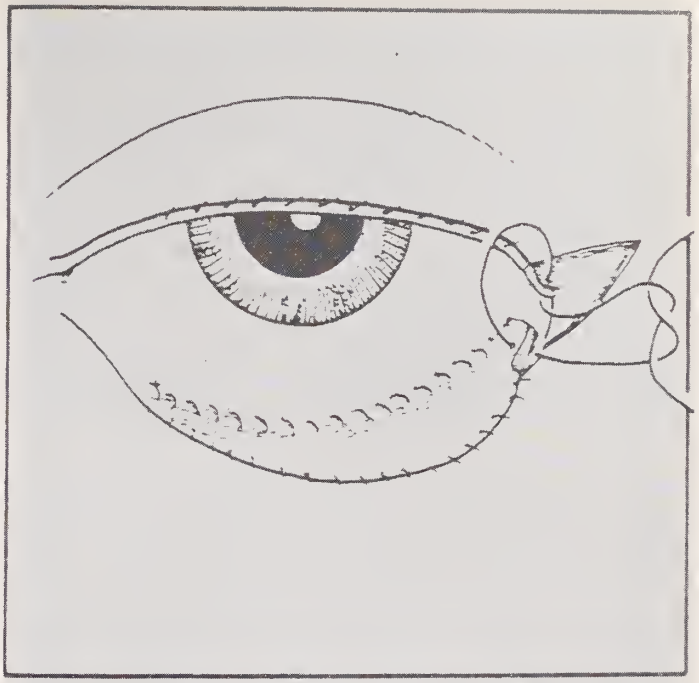


Figure 5 — Closure of fornix incision and lateral canthal tendon reattachment.

ment of the eye or improvement in vision in the patients who have compressive or ischemic optic neuropathy combined with their proptosis.

Figure 7 shows the results in 28 orbits of A-E decompression and four orbits of combined A-E and lateral decompression. All except two patients had bilateral decompression. Two of the decompressions included in this list were not for Graves' Disease but for severe orbital lymphangiomas.

Figure 8 shows the results in patients who suffered from compressive or ischemic optic neuropathy. All neuropathy patients had a previous trial of steroids. All of the patients who underwent decompression responded immediately, with dramatic improvement in vision, easily satisfying Trobe's criteria for effectiveness of therapy.[3] One-third of the neuropathy patients did not improve to better than 20/50 vision. They subsequently underwent super voltage radiotherapy of the apex of the orbit. These patients who required postoperative irradiation were invariably those whose initial vision was less than 20/100.

Complications of the surgical procedure were remarkably mild (Figure 9). Infraorbital anesthesia obviously occurs if the nerve is excised purposefully. After 4 to 6 months in these patients, however, some sensation apparently returns, and they generally have no complaints. In those patients who had pre-existing diplopia, no changes in the pattern of diplopia was noted, and no diplopia was created in patients who had none preoperatively. The amount of fibrosis in the orbit varied from patient to patient. Fibrosis of the orbit definitely lessens the effectiveness of decompression, so it is recommended that

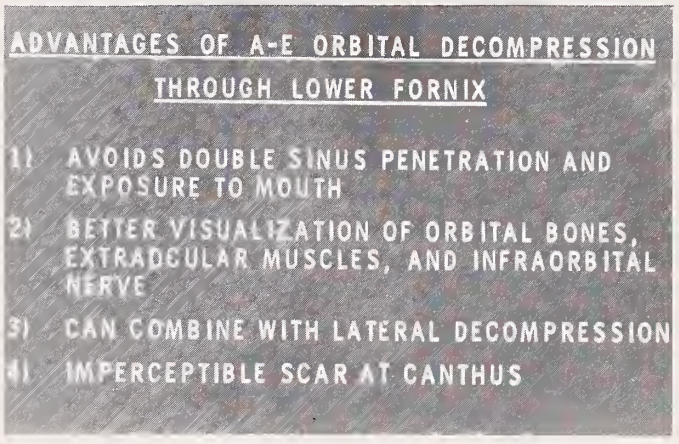


Figure 6 — Advantages of orbital decompression through the lower fornix.

	RETROPLACEMENT OF EYE	PATIENTS
A-E DECOMPRESSION	4-7mm (AVERAGE 6)	14
A-E DECOMPRESSION COMBINED WITH LATERAL DECOMPRESSION	6-8mm	2

Figure 7 — Effect of decompression on eye position.

A-E ORBITAL DECOMPRESSION IN GRAVES DISEASE

	PATIENTS	TRIAL STEROIDS	RECESSION OF LID RETRACTORS	POST OP X-RAY	FINAL VA 20/30 +
OPTIC NEUROPATHY	9	9		3	8 (1 lost)
CORNEAL EXPOSURE OR DISFIGURING EXOPHTHALMOS	5		6		

Figure 8 — Classification of patients with Graves' Disease undergoing decompression and the results in patients with compressive neuropathy.

COMPLICATIONS AND SIDE EFFECTS OF A-E ORBITAL DECOMPRESSION	
INFRAORBITAL ANESTHESIA	7
ADVERSE CHANGES IN OCULAR MUSCLE BALANCE	0
UNDERCORRECTION (ORBITAL FIBROSIS)	3
ASYMMETRY	3
DACRYOSTENOSIS	0
ORBITAL CELLULITIS	0

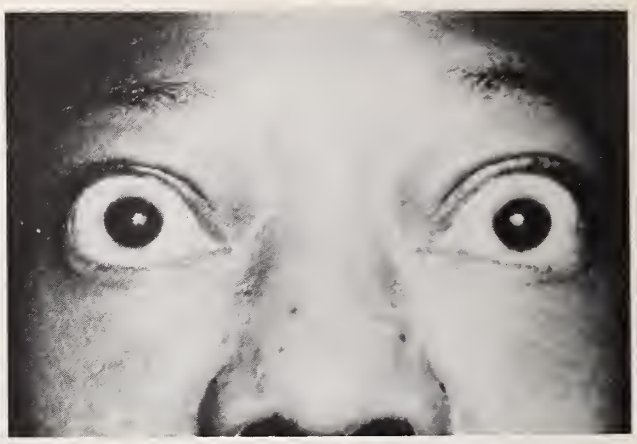
Figure 9 — Complications and side effects of A-E orbital decompression.

when decompression is contemplated, it should be performed before this fibrosis occurs. There is a theoretical contraindication to orbital decompression by this method in patients with purulent sinusitis. However, this circumstance was not encountered in our series.

Clinical Examples

Case #1

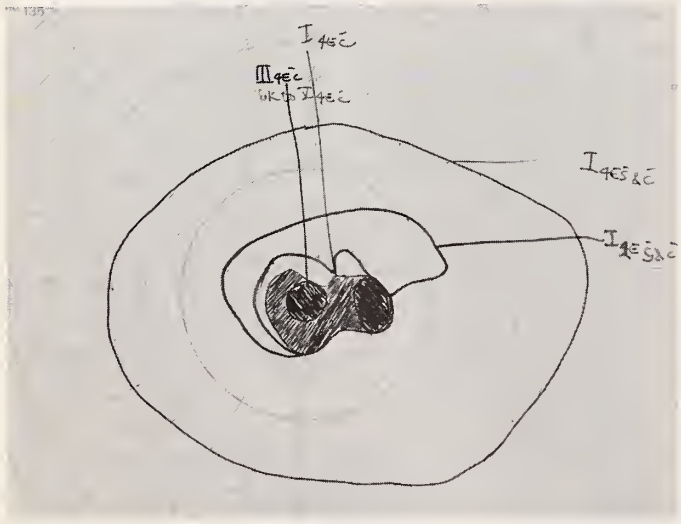
Figures 10a and 10b show a patient with Graves' Disease whose condition has worsened following treatment with radioactive iodine for hyperthyroidism. The treatment produced accelerating proptosis and compressive optic neuropathy, with vision less than 20/200 in each eye. The patient had been on systemic cortisone, 100 mg. of prednisone per day, for 2 weeks. Figures 11a and 11b show the visual field in the right and the left eye before orbital decompression. A-E decompression was performed with retroplacement of the eye (Figures 12a and 12b), and vision improved to 20/60+ in each eye. The visual field showed corresponding improvement

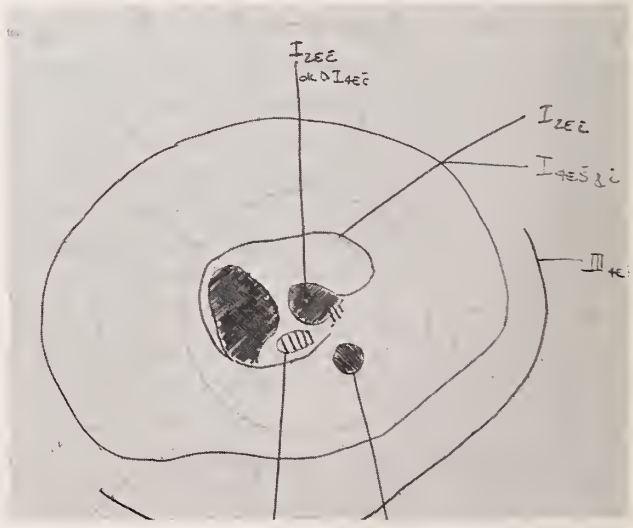




Figures 10a (above) and 10b — Patient 1 with Graves' Disease and compressive neuropathy before A-E decompression.

(Figures 13a and 13b). Super voltage irradiation to the orbit as previously described improved the vision to 20/20 in each eye, with further improvement in the visual field (Figures 14a and 14b).



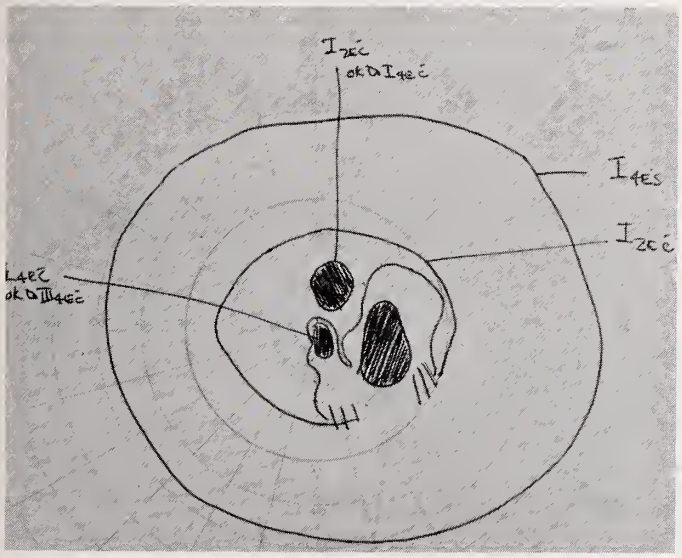


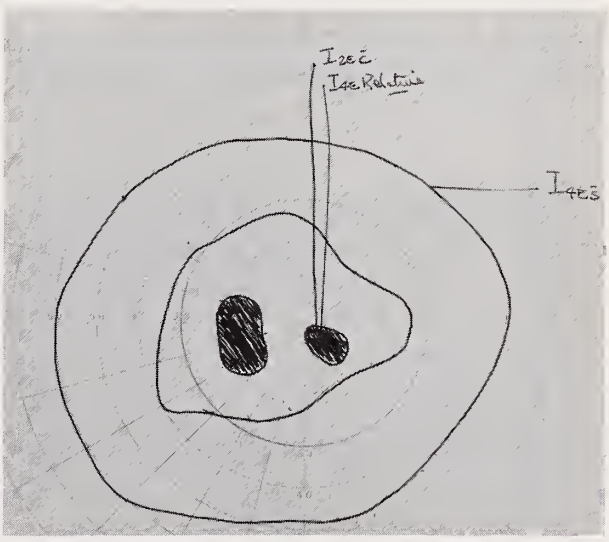
Figures 11a (left) and 11b — Visual field on the right and left eye preoperatively in Patient 1.



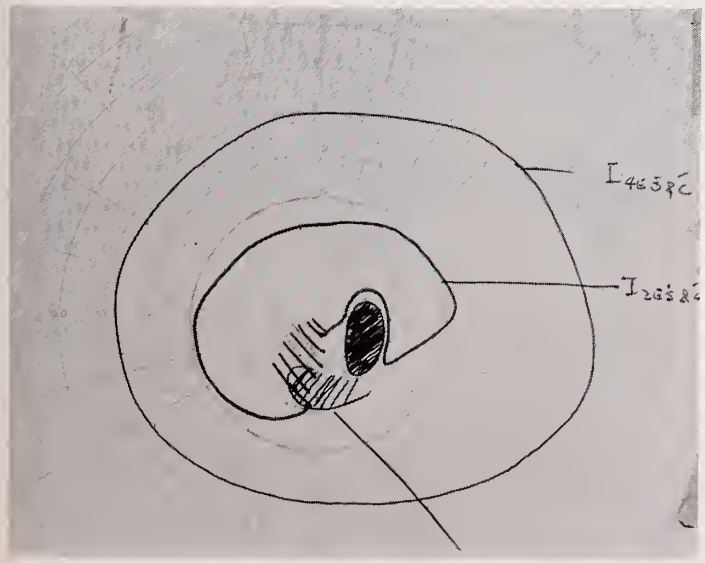


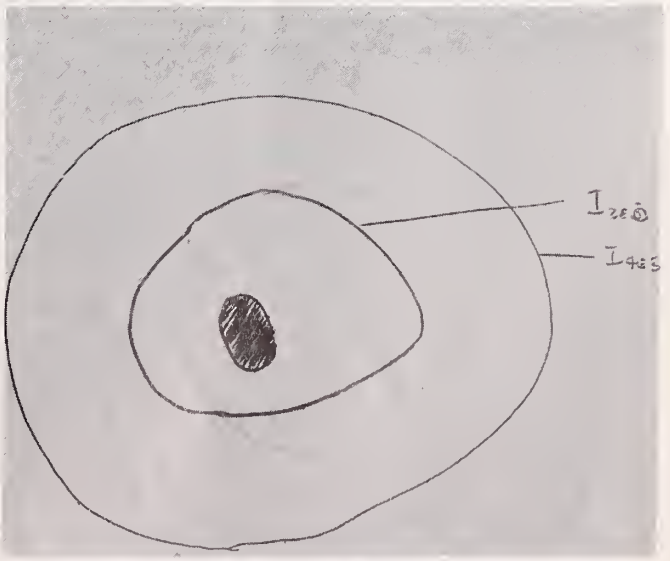
Figures 12a and 12b — Patient 1 postoperatively with some residual upper eyelid retraction on the left.





Figures 13a and 13b — Visual fields of Patient 1 following A-E decompression.





Figures 14a and 14b — Visual fields of Patient 1 following irradiation of orbital apices.

Case #2

Figures 15a and 15b and Figures 16a and 16b show a patient with Graves' Disease and compressive optic neuropathy before and after A-E decompression combined with lateral decompression. Postoperative irradiation was not necessary, as vision improved to 20/20 in each eye with decompression alone.



Figures 15a and 15b — Patient 2 with Graves' Disease and compressive neuropathy before (left) and after A-E decompression combined with lateral decompression (Line shows area of anesthesia of lip).



Figures 16a and 16b — Patient 2 before (left) and after A-E decompression combined with lateral decompression.

Case #3

Figure 17a shows a patient with mild Graves' Disease. A-E decompression relieved proptosis and corneal exposure, and improved the patients appearance (Figure 17b).



Figures 17a and 17b — Patient with mild exophthalmos alone before (left) and after A-E decompression.

Summary

In our experience, the compressive or ischemic optic neuropathy seen in Graves' Disease is best treated initially with systemic cortisone in high doses. A significant number of patients will respond within 2 weeks, and the dosage can be tapered. In patients with neuropathy who are unresponsive to steroids and in patients who have severe proptosis with corneal exposure, orbital decompression (A-E decompression) is performed. Approximately 30% of patients undergoing decompression require supplemental supervoltage irradiation to the orbit to normalize vision. No radiotherapy has been used as the primary modality of therapy.

Graves' Disease can produce frightening visual changes and distressing disfigurement. With the above regimen of therapy, most patients can reach a state of acceptable vision and appearance.

References

1. Mullin B, Levinson RE, Friedman A, Henson DE, Winand RJ, Cokn LD: Delayed hypersensitivity in Graves' Disease and exophthalmos: identification of thyroglobulin in normal human orbital muscle. Endocrinol 1977; 100:351-366.

2. Cant JD, Wilson TM: Ocular and orbital circulation in dysthyroid ophthalmology. Trans Ophthal Soc U.K. 1974; 94:416-429.

3. Trobe JD, Glaser JS, LaFlamme P: Dysthyroid optic neuropathy. Arch of Ophth 1978; 96:1199-1208.

4. Donaldson SS, Bagshaw MA, Kriss JB: Supervoltage orbital radiotherapy for Graves' Disease. J Clin Endocrin Metab 1973; 34:276-285.

5. Naffzigger HC: Progressive exophthalmos following thyroidectomy: its pathology and treatment. Ann Surg 1931; 94:582.

6. Berke RN: A modified kronlein operation. Trans of Amer Oph Soc 1953; 51:193.

7. Hirsch O: Malignant exophthalmos. Arch of Otolary 1950; 51:325.

8. Sewall EC: Operative control of progressive exophthalmos. Arch of Otolary 1936; 24:621.

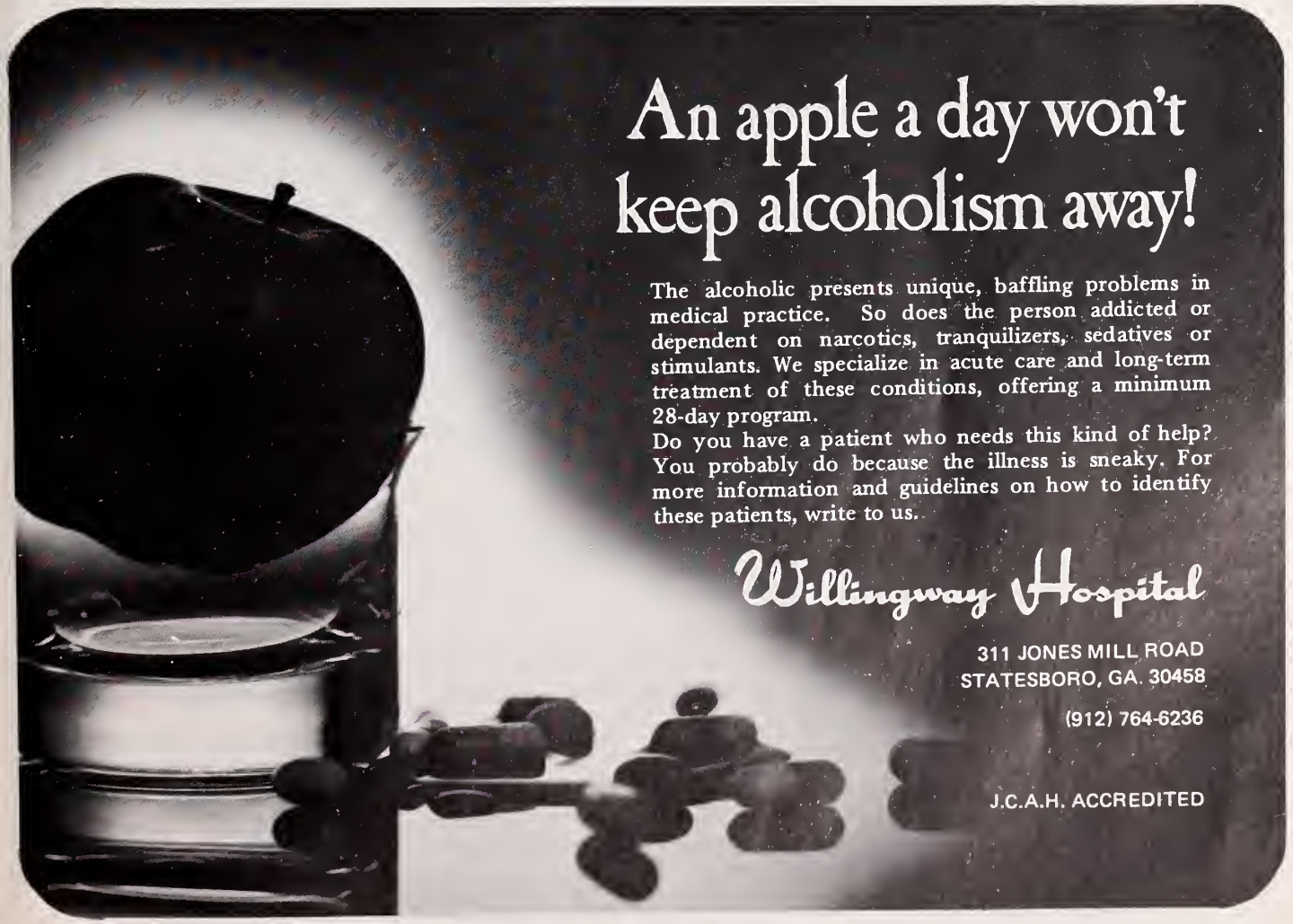
9. Algenere B, Almqvist S, Backlund EO: Pterional orbita decompression and progress ophthalmopathy of Graves' Disease; II. Short term effects. Acta Ophthal (Kbh) 1973; 51:461-474.

10. Ogura JH, Lucente FE: Surgical results of orbital decompression for malignant exophthalmos. Laryng 1974; 84:637.

11. Calcatera TC: Paranasal sinus decompression of the orbit in Graves' Disease. Ophthal Surg 1977; 8:80-84.

12. McCord CD: Antral-ethmoidal orbital decompression through the eyelid approach. Presented at the American Society of Ophthalmic Reconstructive Surgery, October 1976, Dallas (Abst.). Ophthal Surg 1977; 8:102.

13. Cooper WC: Graves' Disease surgical management. *Ocular and Adnexal Tumors*. (ed) F. Jackobiec. Birmingham: Aesculapius Press, 1978.



Informed Consent in Georgia: Previewing the "1980 Model"

ROBERT N. BERG, *Atlanta**

OVER THE PAST few years, we have periodically given *Journal* readers updates regarding the doctrine of "informed consent" as it has evolved under Georgia law.[1] As most of you are aware, this doctrine generally provides that, in the absence of emergency or unanticipated conditions, a physician or surgeon must first obtain the consent of the patient (or someone legally authorized to consent for the patient if he or she is not competent to do so) before treating or operating on the patient. Moreover, for the consent to be effective, it must be given on the basis of an adequate knowledge of the risks involved in the proposed treatment or operation. The failure on the part of the physician to obtain the informed consent of the patient can lead to the imposition of liability on the physician for negligence.

In Georgia, unlike most other states, the doctrine of informed consent has been expressly rejected as a common law doctrine by the courts, so that physicians in Georgia are not under a common law duty to apprise their patients of the risks involved in an operation or treatment. Rather, the duty to disclose placed upon Georgia physicians is a statutory one, arising out of the "Georgia Medical Consent Law."[2] This law was recently interpreted in a case decided by the Georgia Court of Appeals, and this is therefore an opportune time to usher in the decade of the '80s by previewing the "1980 model" of the doctrine of informed consent in Georgia.

The Georgia Medical Consent Law

The Georgia Medical Consent Law provides that certain persons are authorized to consent, either orally or otherwise, to any surgical or medical treatment or procedures which may be suggested, recommended, prescribed, or directed by a duly licensed physician. These persons include:

(1) Any adult, for himself;
(2) Any parent (whether or not an adult) for his or her minor child;
(3) Any married person, for himself or herself, or for his or her spouse;
(4) Any person legally standing in place of a parent, for a child under his or her care;
(5) Any female, regardless of age or marital status, for herself, when given in connection with childbirth or pregnancy (other than in connection with abortion or sterilization);
(6) Any adult, in the absence of a parent, for a minor brother or sister;
(7) Any grandparent, in the absence of a parent, for a minor grandchild; and
(8) Any other person who may be authorized or empowered, with the exception of a person who has been adjudicated incompetent.[3]

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

The Georgia Medical Consent Law goes on to provide that it is to be liberally construed, such that the relationships set forth in that law include adoptive, foster, and step-relations as well as relations of natural whole blood, and include relations by common law marriage as well as by ceremonial marriage. In addition, the law provides that persons acting in good faith are authorized to rely on the representations of the individual giving his or her consent as to that person's identity, age, marital status, emancipation, and relationship to the person for whom the consent is profered.[4]

The Georgia Medical Consent Law deals with the duties placed upon physicians with respect to the necessity of obtaining consents in the context of both emergency and non-emergency situations. As to the former, a consent to surgical or medical treatment or procedures is implied where an emergency exists. In that regard, an emergency is defined as a situation wherein (a) the proposed surgical or medical treatment or procedures are reasonably necessary as determined by competent medical judgment; and (b) a person authorized to consent, as described above, is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the patient, or could reasonably result in disfigurement or impair facilities.[5]

In the non-emergency context, the Georgia Medical Consent Law deals with the nature and scope of the consent in terms of what must be disclosed by the physician to the patient, providing that:

> "(a) consent to medical and surgical treatment which *discloses in general terms the course of treatment* in connection with which it is given and which is duly evidenced in writing and signed by the patient or other person or persons authorized to consent . . . shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations of material facts in obtaining the same." (Emphasis supplied)[6]

In other words, unlike the traditional informed consent doctrine which requires that the patient be informed of the *risks* involved in a treatment or operation,[7] the Georgia Medical Consent Law merely requires that the patient be informed of the *general terms* of the medical or surgical treatment.[8]

Signing Consent Without First Reading It as "Informed"

The recent case referred to above dealt with the question of whether or not a patient would be bound by a written consent which she executed without first fully reading. In that case, *Winfrey v. Citizens & Southern National Bank,*[9] a patient brought an action against the executor of the deceased physician's estate, claiming that the deceased physician had both (1) committed assault and battery on the patient by performing a hysterectomy on the patient without her consent, and (2) breached his statutory duty to her by not obtaining an informed consent prior to performing the operation. The trial court granted the executor's motion for summary judgment on both counts, based in part upon a consent form which had been signed by the patient. The patient appealed this decision to the Georgia Court of Appeals.

The Georgia Court of Appeals affirmed the trial court's decision holding that the fact that the patient had not fully read the consent form before signing it was not a "legally sufficient excuse" and did not dissipate the otherwise binding effect of the consent on the patient.[10] Moreover, the Court held that the nature and content of the consent, which authorized the physician to perform a "laparoscopy, possible laparotomy," and "operations and procedures in addition to or different from those now contemplated, which . . . [the physician] may consider necessary or advisable in the course of the operation," both authorized the physician's performing a hysterectomy on the patient and comported with the requirements of the Georgia Medical Consent Law. Consequently, the Court found that the consent executed by the patient was "(i)n the absence of fraudulent misrepresentations of material fact in obtaining [the patient's] permission . . . conclusively presumed to be a valid consent" under the Georgia Medical Consent Law.[11]

Exceptions to the Medical Consent Law

As we have advised our readers on previous occasions, the Georgia Medical Consent Law expressly provides that it does not apply to the subjects of abortion and sterilization. Consequently, it is necessary to look to the statutes[12] specifically governing those subjects in order to determine the nature and scope of the consents required to be obtained by physicians in either abortion or sterilization situations. In addition, the Georgia Code also contains special rules with respect to two other situations — the treatment of minors for venereal diseases and drug abuse,[13] and the performance or administration of artificial insemination[14] — and physicians should be aware of the necessity of satisfying the criteria set forth in these statutes.

Notes

1. See, Blackstock JB: Informed consent. JMAG (April, 1973); Huff JW: Informed consent and res ipsa loquitur. JMAG (January, 1976); Huff JW: More on informed consent. JMAG (February, 1976); Huff JW: Informed consent — Georgia update. JMAG (September, 1977).
2. *Ga. Code Ann.* §§88-2901 *et seq.*
3. *Ga. Code Ann.* §88-2904.
4. *Ga. Code Ann.* §88-2906.
5. *Ga. Code Ann.* §88-2905.
6. *Ga. Code Ann.* §88-2906.
7. For a survey of the nature of the disclosure requirements under the "informed consent" doctrines in existence in other states, see Annotation, "Modern Status of Views as to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment," 88 A.L.R. 3d 1008 (1978).
8. *Young v. Yarn,* 136 Ga. App. 737, 222, S.E. 2d 113 (1975); *McMullen v. Vaughan,* 138 Ga. App. 718, 227 S.E. 2d 440 (1976); *Parr v. Palmyra Park Hospital, Inc.,* 139 Ga. App. 457, 228 S.E.2d 596 (1976).
9. 149 Ga. App. 488, 254 S.E.2d 725 (1979).
10. 149 Ga. App. at 488.
11. 149 Ga. App. at 489.
12. Abortions are governed by *Ga. Code Ann.* §§26-1201 *et seq.;* sterilizations are governed by the Georgia "Voluntary Sterilization Act," *Ga. Code Ann.* §84-931 *et seq.*
13. *Ga. Code Ann.* §74-104.3.
14. *Ga. Code Ann.* §74-101.1(c).

WHY THE UNITED WAY IS MORE IMPORTANT AFTER PROPOSITION 13 THAN EVER BEFORE.



There's a new attitude in America, typified by Proposition 13.

Americans aren't opposed to helping each other, but they are opposed to bearing the ever rising costs of government. And many of them have decided to put a lid on taxes.

That means that in many places across the country, the government may be doing less than it has been.

Less for people in need of help. Less for everyone.

And that means the United Way is going to have to stretch itself further and more efficiently than ever before.

editorial
editorial
editorial

Commentary on Physician Advertising

THE FEDERAL TRADE COMMISSION (FTC) has ruled that the *Principles of Medical Ethics* unlawfully restrict competitive advertising by physicians. The decision follows 9 months of hearing before an FTC administrative law judge, as well as arguments before the full Commission. The FTC reversed a ruling by its administrative law judge that barred the AMA from having any regulation of physician advertising. Specifically, the AMA may enforce "reasonable ethical guidelines governing the conduct of its members with respect to representation, including unsubstantiated representations that would be false or deceptive . . . or with respect to uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence."

Many persons are convinced that advertising will decrease the costs of health care. For the most part, these persons are politicians, journalists, economists, etc. Their opinion is by no means a majority opinion and there are very few physicians who agree with them. As physicians, we recognize that advertising will not decrease the costs of patient care by providing bargains, cut-rate services, shortcuts, or the like. In reality, advertising will only increase utilization. This means greater expenditures, rather than decreased costs.

We are all aware of the capabilities of high class advertising, particularly with regard to television. Long ago cigarette advertising was banned from television because of its tremendous impact. More recently, organizations are trying to regulate the advertising which is being aimed at children. Advertising is so effective that organizations are willing to spend upwards of $150,000.00 per minute for prime time advertising space. There is no reason to expect that physicians' services or diagnostic studies could not also be promoted.

In reality, advertising will only increase utilization. This means greater expenditures, rather than decreased costs.

Many Americans do not have any knowledge whatsoever about an "executive health examination" or preventive medicine. An effective campaign could certainly double, triple, or quadruple the number of annual health examinations performed in this nation. Similarly, cosmetic surgeons, if allowed to advertise on television, could literally overpower the public with the very dramatic results they are able to achieve. Somebody who had a CT scanner could advertise so effectively that just about everybody with a headache would feel justified in getting such a scan. After all, "the insurance will pay for it."

Not only would advertising result in over-utilization of good and appropriate services, it would also emphasize and promote inappropriate services. A good example lies in the various analgesic over-the-counter medications which have been advertised for years, and only recently has the FTC ruled that there is, in fact, no difference at all between the preparations, as has been claimed. Unscrupulous

advertising of medical, surgical, psychiatric, or other practice could occur and persist for many years before the process of evaluation control and retraction occurred. During that time much harm to the public could be done.

Another very significant area of hazard would be public confusion regarding various degrees, titles, societies, certifications, etc. We are already aware that non-physicians like to place the term "Dr." in front of their names. The other designations would be just so much alphabet soup to the unwitting public. Even though we try hard, most of us cannot knowledgeably interpret the differences between bottles of wine by reading the labels from such places as France, Germany, Italy, New York State, California, and elsewhere. Similarly, it is entirely unrealistic to expect the public to knowledgeably differentiate between physicians, osteopaths, chiropractors, optometrists, psychologists, hypnotists, physical therapists, etc., simply by reading their respective advertisements.

Regardless of the claims made by well-meaning but misinformed persons, medical advertising could only have an overall deleterious effect on both the health and costs of health in America. The Medical Association of Georgia has a committee on truthful advertising and welcomes any comments, suggestions, or examples of fraudulent advertising which you might have.

Richard E. DuBois, M.D.
Chairman
Committee on Truthful Advertising
Medical Association of Georgia

THE GOVERNMENT CAN DO EVERYTHING THE UNITED WAY DOES. ONLY THEY WRAP IT UP FOR YOU IN NICE RED RIBBON. MILES AND MILES OF IT.



One of the best things about United Way is not what it *does,* but what it *doesn't* do.

Because United Way is run almost entirely by volunteers, it is able to return an amazing 89¢ of every dollar to people who need it. So it doesn't waste your money.

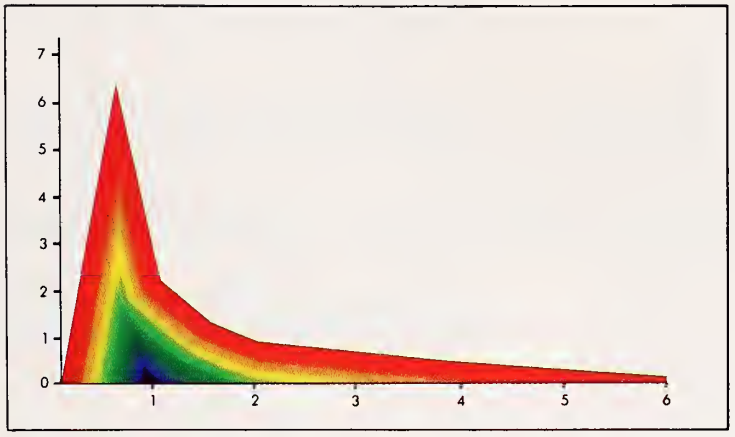
And because United Way is re-created each year with a combination of old and new volunteers, it doesn't become over encumbered with huge permanent staffs.

So it doesn't strangle you in red tape.

All of which means that because of what United Way *doesn't* do, it can do a much better job at what it *does* do. Helping people.

Thanks to you, it works. For all of us. United Way

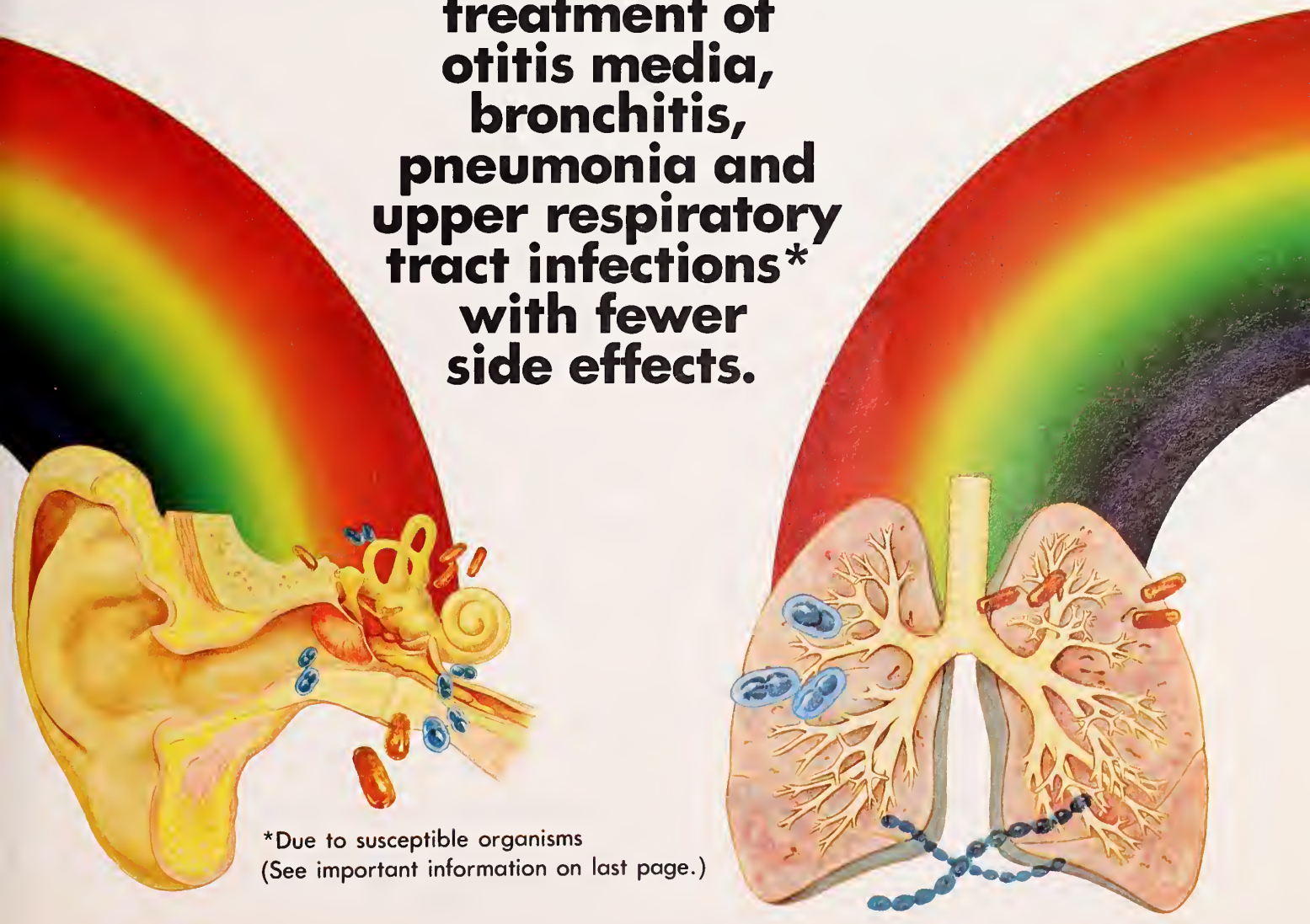
more than just spectrum



New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of otitis media, bronchitis, pneumonia and upper respiratory tract infections* with fewer side effects.



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN®
(cyclacillin) Tablets/ Suspension

efficacy with fewer side ampicillin confirmed in studies of 2,581

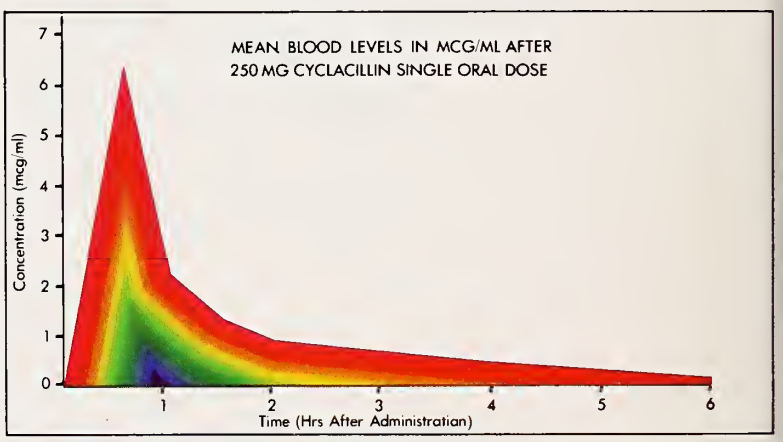
Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin





Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
S. pneumoniae	96 % Clinical Response 95 % Bacterial Eradication	82
H. influenzae	88 % Clinical Response 85 % Bacterial Eradication	96

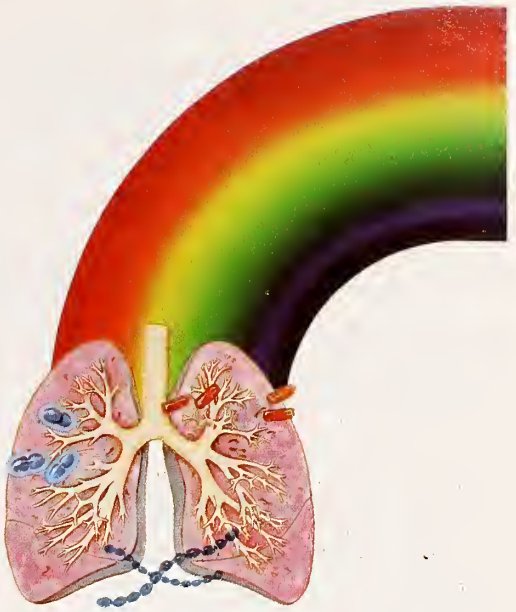
more than just spectrum in otitis media

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

Copyright © 1979, Wyeth Laboratories. All rights reserved.

effects than double-blind patients*



Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant (P <0.001)	

In bronchitis, pneumonia and upper respiratory tract infections†

High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100 % Clinical Response; 95 % Bacterial Eradication	73
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100 % Clinical Response; 86 % Bacterial Eradication	44

CYCLAPEN® (cyclacillin)
Effective for otitis media† in children

- Excellent clinical results in eliminating the two most common causative organisms in otitis media
- Significantly lower incidence of diarrhea and skin rash in children treated with CYCLAPEN® Suspension

	diarrhea	rash
CYCLAPEN	9.1%	2.1%
ampicillin	19.2%	5.8%
	P < 0.001	P < 0.03

more than just spectrum

CYCLAPEN®

(cyclacillin) Tablets/ Suspension

1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.

(See important information on next page.)

Wyeth Laboratories
Philadelphia, Pa 19101

New from Wyeth Laboratories

CYCLAPEN®

(cyclacillin) Tablets/ Suspension



Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase prodocers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight ≥20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥ 10 mg %, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

CYCLAPEN® (cyclacillin) for oral suspension

125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Wyeth Laboratories
Philadelphia, Pa. 19101

Nutrition and Maintenance of Cardiovascular Health

SARA M. HUNT, Ph.D., *Atlanta**

THE HIGH INCIDENCE of obesity in this country, as well as the suggestive evidence of a relationship between nutrition and development of various degenerative diseases, e.g. cardiovascular disease, led to the formulation in 1977 (and revision in 1978) of certain dietary goals for people in the United States. These goals, devised by the Senate Select Committee on Nutrition and Human Needs, can be converted into nutrition guidelines appropriate for most adults, particularly those approaching middle age. The following six guidelines not only hold some promise toward slowing down development of certain degenerative diseases but also foster eating habits that promote vitality and a feeling of well being:

Guideline #1 — Consume energy in the amount which will allow attainment and maintenance of ideal body weight. Maintaining ideal body weight has its own esthetic value but more importantly it is excellent preventive medicine. Diseases such as diabetes and hypertension, both of which impact heavily on the development of cardiovascular disease, are more easily controlled in the person of normal weight than in one who is obese.

Unfortunately, weight control is never easy, notwithstanding all the so-called "easy" weight loss plans sold in bookstores and on newsstands. The number of these "easy" plans that abound attests to the fact that none has proved to be very successful. Any successful weight reduction program requires determination, perseverence, and discipline. Furthermore, in order for weight loss to be maintained, eating habits compatible with weight control must be developed during the active stage of weight loss. Excellent suggestions for those serious about weight control have been made recently by Edwin Bayrd[1] and approved by the Mayo Clinic. These suggestions include:

1. Drink one pint of skim milk daily and then consume as few calories as possible in the form of other liquids. This means eliminating all alcoholic and sweetened beverages from the diet. Fruit juices at breakfast should be low in calories but high in ascorbic acid, e.g. unsweetened grapefruit juice, tomato juice.
2. Eat nothing fried in deep fat. Every gram of fat consumed supplies 9 calories.
3. Choose sources of protein with care, especially those lower in fat, i.e. fish, poultry, and veal, and limiting those high in fat, i.e. beef and pork. Grill or bake all meats.
4. Completely eliminate the use of butter or margarine. Small curd cottage

* Dr. Hunt is Chairman of the Department of Community Health Nutrition at Georgia State University, University Plaza, Atlanta, GA 30303. She is Vice-Chairman of the Nutrition Committee, Georgia Affiliate of the American Heart Association. This article originally appeared in the October 1979 issue of *Atlanta Medicine* and is reprinted here in revised form by permission of the Editorial Board of that publication.

Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

cheese may be used as a spread on breakfast toast; vegetables may be seasoned with lemon juice, lemon pepper, and various herbs; mustard can replace mayonnaise and butter on sandwiches. (Soy sauce is also an excellent seasoning for vegetables, but it is very high in sodium.)

5. Begin each dinner with a mixed green salad tossed with a low-calorie dressing, and eat this 30 minutes before the main meal. This reduces hunger pangs and prevents overeating at dinner.

6. With hunger under control, eat the same dinner everyone else is having but have it on a smaller plate and have only half as much. Attempt to always leave something on the plate. (This is an example of behavior modification which is needed by all of us who were taught in childhood to clean our plates.)

7. Snack on low-calorie foods. Good examples of appropriate snacks are raw vegetables and unbuttered popcorn.

8. Avoid dessert unless it is unsweetened fresh fruits such as melon, pears, grapes.

9. Spend an additional 30 minutes each day in walking or in some kind of an enjoyable exercise appropriate for your age.

Once ideal body weight has been reached, many of the aforementioned diet restrictions may be relaxed somewhat, but reduction in fat and sugar consumption should become habitual.

Guideline #2 — Increase consumption of fruits, vegetables, and whole grains. Clearly, this guideline is appropriate for weight watchers as well as for those interested in obtaining generous amounts of vitamins, minerals, and fiber in their diet. Several servings daily of these foods alleviate the need of expensive dietary supplements. It is necessary, however, to be careful about the storage and preparation of vegetables so as to preserve their nutritive value.

Whole grain breads and cereals should replace refined ones in order to supply those vitamins and minerals which have been removed in the milling process and not replaced through enrichment. Examples of vitamins and minerals found in greater abundance in whole grain products than in refined ones include Vitamin E, folic acid, pyridoxine, magnesium, and zinc.

Another advantage of whole grain products is their high fiber content. Although the exact role of fiber in preventive medicine is still uncertain, epidemiologic studies suggest that it may be helpful in protecting against many diseases, and that certain types of fiber may even be effective in controlling serum lipids and blood glucose by decreasing absorption of these nutrients. One beneficial aspect of fiber is certain: it does decrease transit time of the feces, thereby helping in the relief of constipation and promoting a feeling of better health.

In addition to all the healthful aspects of whole grain products, there is always their extra taste appeal. What could possibly be better than home-baked bread made from whole grain flour? Furthermore, the importance of grains in supplying protein to the diet must not be overlooked. Although cereal protein is not complete in itself, it can be made complete through combination with protein found in legumes, i.e. vegetables such as peas and beans. Obtaining protein from such food combinations allows a decrease in meat consumption and therefore a decrease in fat and cholesterol intake.

Guideline #3 — Decrease consumption of refined and processed sugars, and foods high in these sugars. Contrary to a rather popular notion about sugar, it is *not* an anti-nutrient. The decrease in sugar consumption is encouraged primarily because it contains only calories, i.e. it is unaccompanied by other nutrients. All too often because of their taste appeal, foods high in sugar may replace food items which would have provided more nourishment. Another danger is that foods high in sugar may be used to such an extent that a person's total caloric intake is much greater than his/her energy expenditure. This positive energy balance inevitably leads to overweight or obesity, a condition which predisposes one to many diseases including hypertension.

Guideline #4 — Decrease consumption of foods high in total fat and partially replace saturated fats with polyunsaturated fats. A decrease in the

total fat content of the diet and an increased polyunsaturated to saturated fat ratio has been recommended for years by persons involved in cardiovascular research. First of all, a decrease in total fat intake usually results in a decreased calorie consumption, thereby helping to control body weight. Secondly, a decreased total fat intake guarantees a somewhat decreased consumption of saturated fats, the intake level of which appears to correlate positively with serum cholesterol values.

The suggestion that polyunsaturated fats partially replace saturated ones is based on the fact that, in contrast to saturated fats, polyunsaturated fats tend to lower serum cholesterol. Whether serum cholesterol has any role in the development of coronary artery disease is debatable, but an elevated serum cholesterol level appears to be a harbinger of potential difficulty.

The following are practical methods by which total fat intake may be reduced while the polyunsaturated/saturated ratio is increased:

1. Select lean cuts of meat and trim off all visible fat.
2. Frequently substitute poultry and fish for red meats, since the fat of the former contains more polyunsaturated fatty acids.
3. Frequently choose vegetable protein, i.e. legumes combined with cereals, to replace animal protein.
4. Substitute low-fat or non-fat milk for whole milk (except for the young child) and carefully select various milk products so as to avoid overconsumption of high fat cheeses and frozen desserts.

Guideline #5 — Decrease consumption of foods high in cholesterol. This recommendation has been around a long time — ever since the observation that an elevated serum cholesterol may be a factor in contributing to cardiovascular disease. All too often people have interpreted this recommendation as meaning total elimination of eggs from the diet because of the high cholesterol content of egg yolks. Although eggs and organ meats (e.g. liver) probably should be used in moderation, they should continue to have a place in the diet, particularly in the diets of young children and the elderly. Don't forget that eggs are a superb source of protein, and liver abounds in vitamins and minerals. Moderation is the key!

An excellent approach to decreasing dietary cholesterol is through decreased consumption of animal products in general. Cholesterol is found only in animal products and is primarily associated with animal fat.

Guideline #6 — Decrease consumption of salt and foods high in salt content. Although the human's need for sodium is approximately ¼ gram per day, the American public consumes so much salt that a person's sodium intake is likely to fall between 2½ and 7 grams daily. Excessive consumption of sodium can be detrimental to persons genetically susceptible to hypertension. Furthermore, there is little way of knowing who these susceptible persons are until the clinical manifestations of this disease have appeared. For this reason, it is wise to learn to eat food without additional salting at the table and to be careful about consumption of obviously very salty foods. Foods such as salted nuts, potato chips, corn chips, and processed meats, should be eaten sparingly.

One great advantage of cutting down on the use of salt is the discovery of the delicious flavor of the food itself. Try eating unsalted foods for at least 1 week. You may discover many wonderful food flavors to your liking and be less inclined to be heavy handed with the salt shaker.

In summary, certain nutrition practices have important implications for the maintenance of health, particularly health of the cardiovascular system. These practices can be concisely stated: achieve and maintain ideal body weight; increase the intake of fruits, vegetables, and whole grain cereals while restricting the intake of salt, sugar, fat and animal products high in saturated fats and cholesterol; practice moderation in eating at all times and avoid bizarre eating habits. These practices, plus appropriate exercise habits and plenty of rest, should do much to improve the quality of life while possibly increasing longevity as well.

Reference

1. Bayrd E: The healthiest way you'll ever lose 10 pounds in two weeks. Family Health, July/August 1979.

Medical F.A.C.S. from Diacon: for physicians who know their business.



Now you can own F.A.C.S., the in-house computer-based Financial Analysis and Control System designed expressly for the individual practitioner or small group practice . . . at a fraction of your present billing costs alone.

Easy to install and easy to use, Medical F.A.C.S. not only puts patient financial and clinical data at your fingertips, but also enhances cash flow and improves your bottom line.

F.A.C.S. . . .

- Is easy to operate. Anyone who can type can use F.A.C.S.
- Bills patients at time of service, putting more of your services on a cash basis.
- Reduces tedium for your staff. They can easily and quickly prepare statements, third party claims and other forms.
- Produces ageing reports to identify past due accounts, allowing faster follow up by your staff.
- Automatically generates patient recall forms, so you can expand the volume of your practice with your present patient base.

These are only a few of the features and benefits. Your Diacon representative will give you details on how Medical F.A.C.S. organizes and controls the business aspects of your practice while you concentrate on providing quality patient care. Phone him at 404-458-8722

Diacon Systems Corporation
4340 Georgetown Square
Atlanta, Georgia 30338

DIACON

Because your practice is your business.

Reasons for Optimism in Childhood Cancers

TAE H. KIM, M.D., and ABDELSALAM H. RAGAB, M.D., *Atlanta**

Introduction

CANCER IS THE SECOND most common cause of childhood death (after accidents) in the United States. That notwithstanding, advances in the treatment of childhood cancers are being reported with increasing frequency, especially in the management of cases of acute lymphocytic leukemia, Wilms' Tumor, Hodgkin's Disease, non-Hodgkin's lymphoma, rhabdomyosarcoma, and osteogenic sarcoma.

The clinical trials of combination chemotherapy in recent years have substantially contributed to increased survival rates in pediatric oncology. In addition, the emphasis in a thorough interdisciplinary approach involving radiologist, pathologist, surgeon, radiation therapist, and pediatric oncologist has completely reversed the traditionally grim prognosis in several types of pediatric solid tumors.

Acute Lymphocytic Leukemia

Acute lymphocytic leukemia is the most common malignancy in children and until recently has been regarded as invariably fatal. Leukemia therapy had its beginning in 1948 when Farber[1] pioneered the use of a folic acid antagonist, aminopterin. As more new agents were discovered, carefully implemented clinical trials of intensive combination chemotherapy have been conducted. It is now possible to achieve a continuous, sustained remission for 5 years in 50% of patients treated, and the majority will remain disease-free.

Review of the chemotherapeutic agents and combination programs in the management of childhood leukemia is beyond the scope of this discussion. However, a new semi-synthetic anthracycline antibiotic called rubidazone deserves special comment. Jacquillat[2] reported that when rubidazone was used on patients at the time of initial diagnosis, complete remission was achieved in 57% of those with acute myelogenous leukemia (AML) and in 80% of those with acute lymphocytic leukemia (ALL) (for both adults and children). When used to treat relapse cases, rubidazone produced complete remission in 45% of the patients with AML and in 46% of the patients with ALL. Our experience with this drug has been equally rewarding, with a current remission rate of about 60%, even in children with history of multiple relapses. One such child treated in our institution remained in remission for more than 6 months.

CNS prophylaxis in the form of intrathecal methotrexate alone or in combination with cranial irradiation has proved to be a most significant contribution to the

* Drs. Kim and Ragab are from the Division of Pediatric Hematology/Oncology, Department of Pediatrics, Emory University School of Medicine. Dr. Ragab is the recipient of a Faculty Research Award from the American Cancer Society. This paper was supported in part by NIH grant #CA20549 and the CURE Foundation of Georgia. Address reprint requests to Tae H. Kim, M.D., Division of Pediatric Hematology/Oncology, Department of Pediatrics, Emory University School of Medicine, 69 Butler St., SW, Atlanta, GA 30303. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

management of children with ALL. In contrast to the 50% incidence of CNS leukemia during the 1960s, less than 10% of children with ALL now experience CNS disease following effective CNS prophylaxis.

Better supportive therapy has played a major role in the increasing survival rates for children with acute leukemias. One of the most significant complications of chemotherapy is myelosuppression that requires hematologic supportive care. Techniques for platelet and granulocyte pheresis have improved over the past several years. With the use of modern continuous-flow cell separators, many children are being saved from early death caused by hemorrhage and sepsis. Infection remains the leading cause of morbidity and mortality in children with leukemia who are immunosuppressed and often leukopenic. The major protozoal infection, pneumocystis pneumonia, has been a frequent cause of death, and the mortality approaches 100% if untreated. Even if treated early and adequately, about 25% of the children will still die. Trimethoprim-sulfamethoxazole is highly effective in preventing the development of *Pneumocystis carinii* pneumonia.[3] In our institution, all patients with leukemia receive Bactrim routinely with the result that, in the past 2 years, not one has contracted pneumocystis infection.

ALL in children has been classified into three subtypes by immunologic markers. This classification has had a proven predictive value, and it is likely that this subclassification at the time of diagnosis will help in selecting a treatment regimen. The majority of children have null-cell leukemia, and it is expected that 70% of these children will experience lengthy leukemia-free survival, whereas children with either T-cell or B-cell markers will do poorly.

Wilms' Tumor

Of the solid tumors in children, Wilms' tumor has been the one most successfully treated and offers the best chance of cure when combined modality care (surgery, radiation therapy, and chemotherapy) is provided. The current cure rate of Wilms' tumor is as high as 90% in Stages I, II, and III, and over 60% in stage IV tumors.

The National Wilms' Tumor Study (NWTS), a multi-institutional investigation organized in 1969, has been largely responsible for the better understanding of the clinical and pathologic aspects of the tumor. It was found that routine post-operative irradiation of the tumor bed is not necessary with Group I tumors. The study also demonstrated that in Group II and III diseases combined treatment with Actinomycin-D and Vincristine over a period of 15 months is superior to the use of either agent alone. All these Group II and III children received post-operative abdominal irradiation. It is also suggested that fewer courses of Actinomycin-D and Vincristine be given to Group I patients without jeopardizing their survival and that the addition of Adriamycin increases survival in children with more advanced stages. The NWTS also identified histologic features that are associated with an unfavorable outcome. These include tumors with anaplasia or sarcomatous characteristics.[4]

Hodgkin's Disease

Hodgkin's disease, which was once usually fatal, can now be cured in the majority of newly diagnosed patients. Surgical staging procedures with laparotomy and splenectomy[5] and the introduction of combination MOPP chemotherapy,[6] as well as better utilization of radiotherapy, have all played a major part in increasing the rate of cure. Radiation therapy is given to Stage I and II disease and total nodal radiotherapy to Stage III-A. Combination chemotherapy is primarily used for patients with Stage III-B and IV disease and for all those who fail to respond to initial radiation therapy program. Total nodal radiation therapy is seldom recommended for children, as it is fraught with complications.

The best hope for cure of Hodgkin's disease in children depends on vigorous initial therapy to eradicate all foci of the disease. Recently, the addition of bleomycin to the widely used MOPP protocol has improved the survival rate. A-COP plus chemotherapy, utilizing the potent antitumor effect of Adriamycin, has also been

introduced. It is hoped that new multi-agent combinations will also reverse the poor prognosis of Stage IV disease.

As children survive longer, efforts are being directed toward minimization of growth retardation, secondary tumors, and aspermia — all complications of intensive chemotherapy and radiation therapy. Of concern is the development of serious and overwhelming infections following splenectomy employed as part of the staging investigation.[7] Prophylactic penicillin is widely used to prevent these infections. The value of pneumococcal vaccination has not been fully established.

Non-Hodgkin's Lymphoma

Non-Hodgkin's lymphoma in childhood is clearly a heterogenous group of disorders with different natural courses and prognosis. Unlike Hodgkin's diseases, therapy has been less effective in this group. The Rappaport classification developed for adults is less useful when applied to childhood cases, owing to the rarity of the nodular histologic type in children. Efforts are being made to classify tumor cells by histochemical and immunologic markers, and it is hoped that the reappraisal of these heterogenous disorders will result in a more effective plan of treatment.

Wollner and co-workers[8] obtained very encouraging results using a 10-drug regimen combined with radiation and prophylactic CNS therapy. Of 43 patients treated, 76% are free of disease, with a median follow-up of 25+ months. Fifty-one percent of the survivors are off therapy and without evidence of disease. Weinstein and co-workers[9] also reported successful results in 12 children who had mediastinal lymphocytic lymphoma. With a median follow-up of 41 months, 86% of these patients are in continuous complete remission when treated with combination chemotherapy, CNS prophylaxis, and mediastinal irradiation.

Rhabdomyosarcoma

Rhabdomyosarcoma, the most common soft tissue sarcoma in children, was regarded as fatal as recently as the past decade. However, considerable progress has been achieved in the management of children with this tumor. At present, the 2-year relapse-free survival rates are projected to be 85% for Group I, 72% for Group II, 60% for Group III, and 25% for Group IV disease, with the overall survival rates being higher for each group.[10] The Intergroup Rhabdomyosarcoma Study has shown that clinical staging for the tumor is of prognostic value, and the outcome varies with the location of the primary tumor. It is generally believed that the best survival rate occurs with the embryonal type and the poorest with alveolar rhabdomyosarcoma.

The role of chemotherapy in rhabdomyosarcoma has changed from one of adjuvant therapy to one of primary therapy. Intensive combinations utilizing Vincristine, Actinomycin-D, and Cyclophosphamide with or without Adriamycin are used in all stages and are known to be effective. Studies are underway with newer agents. Because of the recognition of effective radiation and chemotherapy, a less mutilative surgical approach is being suggested to avoid the disability associated with extensive surgery such as the pelvic exenteration or forequarter amputation.

It is to be noted that the chest CT scans have been sensitive in detecting early pulmonary metastatic lesions in these patients. This accurate staging will undoubtedly lead to better treatment planning and increased survival rates.

Osteogenic Sarcoma

Osteogenic sarcoma, the most frequent primary malignant bone tumor in childhood, has a tendency to disseminate rapidly. Surgery and radiation therapy have had little beneficial effect. However, aggressive chemotherapy, using high doses of methotrexate with Citrovorum Rescue and Adriamycin, has altered the prognosis considerably.

Until recently, the long-term survival rate has been less than 20% when treated

with conventional radical surgery with or without radiation therapy. When given adjuvant chemotherapy, using high doses of methotrexate and other antitumor agents, 50% or more patients will remain disease-free after 2 years.

Summary

In the past 2 decades, there has been rapid progress in the successful management of childhood cancers. Progress from this point will depend on ongoing research into cellular kinetics, mechanisms of drug action, molecular biology, and tumor immunology, and on a better understanding of the natural history of each tumor. Further improvements in supportive therapy that includes total parenteral nutrition and improved diagnostic procedures are also necessary.

Ideally, all children with tumors should be treated by a team specifically experienced in the management of childhood malignancies and should be included in prospective randomized studies. Close collaboration among specialists from initial diagnostic procedures through therapy is essential. As more patients with tumors are becoming long-term survivors, attention is being focused on chronic disabilities, with a strong emphasis now being directed toward rehabilitation.

While more patients are being treated by highly trained specialists, primary pediatricians may feel separated from their patients. However, his or her role in the early recognition of the tumor has become more crucial. The primary physician should still manage his or her patients jointly with the cancer treatment center.

In patients with cancer, psychologic support is one of the most important parts of therapy. In our center, our nurses are specially trained in pediatric oncology. They work in both inpatient and outpatient services, rendering uninterrupted high-level care and psychologic support to both the children and their parents and other relatives. Frequently, parents who have had experience with the disease in their own children communicate with the new patients and their parents. They exchange information and give support at the time when emotional support is needed most.

This year we have been very fortunate to see the Children's Oncology Services of Georgia open the Atlanta-area Ronald McDonald House. It is the fourth Ronald McDonald House in the country. Parents of children who are undergoing treatment in our center are now staying there, so that much of the financial and emotional hardship on these families has thus been alleviated.

References

1. Farber S, Diamond LK, Mercer RD, et al.: Temporary remissions in acute leukemia in children produced by folic acid antagonist 4-aminopteroylglutamic acid, aminopterin. New Engl J Med 1948; 238:787-793.

2. Jacquillat C, Weil M, Gemon-Auclerc MF, et al.: Clinical study of rubidazone (22 050 RP). A new daunorubicin derived compound in 170 patients with acute leukemia and other malignancies. Cancer 1976; 37:653-659.

3. Hughes WT, Kuhn S, Chaudhary S, et al.: Successful chemoprophylaxis for *Pneumocystis carinii* pneumonitis. New Engl J Med 1977; 297:1419-1426.

4. Beckwith JB, Palmer NF: Histopathology and prognosis of Wilms' tumor: results of the first National Wilms' Tumor Study. Cancer 1978; 41:1937-1948.

5. Glatstein E, Guernsey JM, Rosenberg SA, et al.: The value of laparotomy and splenectomy in the staging of Hodgkin's Disease. Cancer 1969; 24:709-718.

6. DeVita VT Jr, Sperpick AA, Carbone PP: Combination chemotherapy in the treatment of advanced Hodgkin's Disease. Ann Intern Med 1970; 73:881-895.

7. Chilcote RR, Baehner RL, Hammond D: Septicemia and meningitis in children splenectomized for Hodgkin's Disease. New Engl J Med 1976; 295:798-800.

8. Wollner N, Burchenal JH, Lieberman PH, et al.: Non-Hodgkin's lymphoma in children. A comparative study of two modalities of therapy. Cancer 1976; 37:123-134.

9. Weinstein HJ, Vance ZB, Jaffe N, et al.: Improved prognosis of patients with mediastinal lymphoblastic lymphoma. Blood 1979; 53:687-694.

10. Maurer HM: Current concepts in cancer. Solid tumors in children. New Engl J Med 1978; 299:1345-1348.

The Complete Communication Company...

OFFICE COMMUNICATIONS INCORPORATED*

e Portables



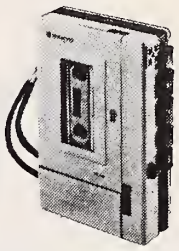
NORELCO NT-1



NORELCO 185

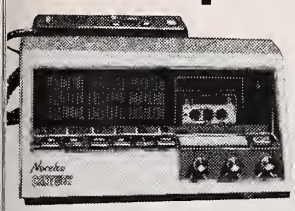


DORO 706



SANYO 1500

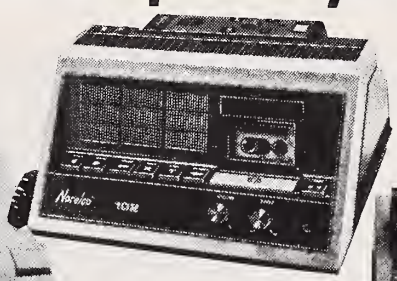
Desk Top Dictation/Transcription Systems



NORELCO CENTURY



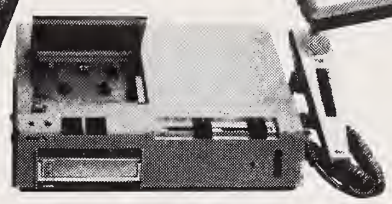
DORO 707



DORO 705

NORELCO 102





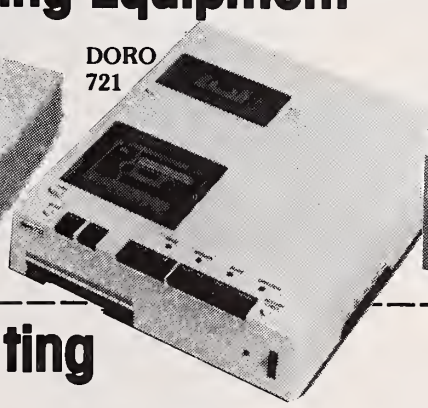
NORELCO 186

Phone Answering Equipment

SANYO 139



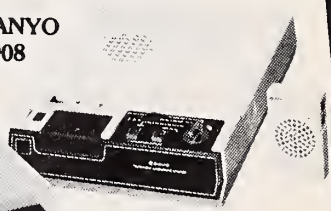
DORO 721



DORO 320



SANYO 9908

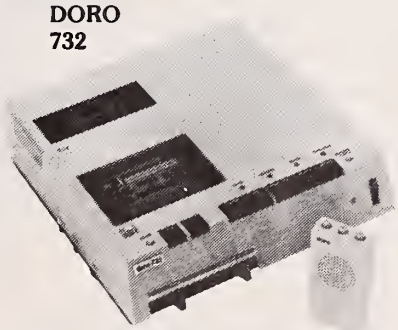


Telephone Dictating

NORELCO 260



DORO 732



*One Stop Communications Sales and Service...

OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry: Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service department throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED

6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741

Peachford Hospita
A uniquely positive, comprehensi

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

PROGRAMS

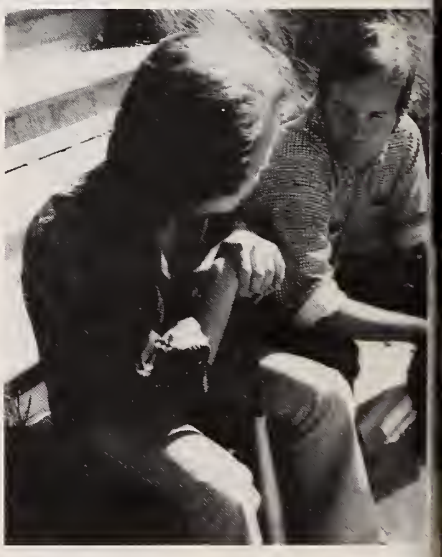
ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge. Twenty-four hour admittance is offered for all programs.





MEDICAL SERVICE DIRECTORS

BOAZ HARRIS, M.D.
Medical Director

CONWAY HUNTER, JR., M.D.
Director, Addictive Disease Unit

CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

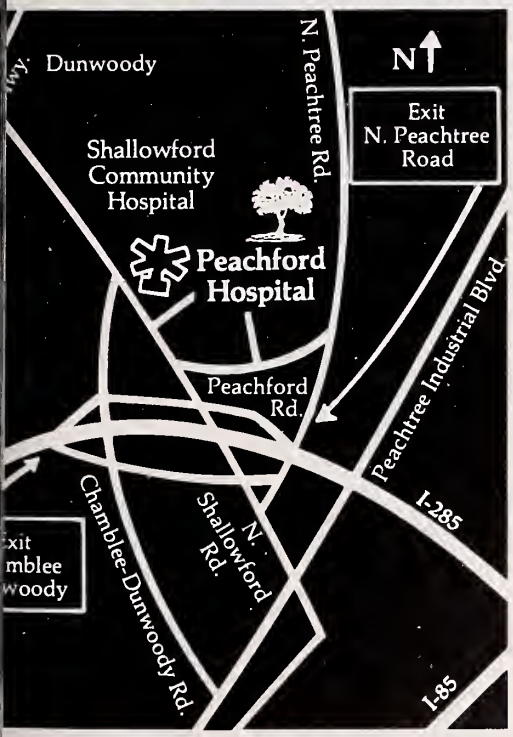
JOHN B. HARDMAN, M.D.
Director, Children's Unit

ogram of recovery...that's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

mplete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30338
Phone (404) 455-3200



president's letter



Setting the Record Straight

RECENTLY I appeared on the television program, "Georgia Forum," with the vice-president of the Federation of American Hospitals, an executive of the Life of Georgia Insurance Company, and a physician bureaucrat representing the administration's National Health Insurance Plan.

The Administration representative made several inaccurate and irresponsible statements, such as, "Physicians' fees, hospital costs, and medical costs have risen higher and faster than everything else." My attempts to correct him with accurate facts and figures were in vain.

So I want to set the record straight and have you pass it on to your patients.

Physicians' average net income rose 5.3% per year in the period 1970-1978, less than the 6.7% average yearly increase for all goods and services as measured by the Consumer Price Index (CPI). The percentage growth in physicians' average net incomes was 2.9% in both 1977 and 1978, while the CPI's all-items index was 6.5% in 1977 and 7.7% in 1978.

Below are some figures of cost increases from 1967 through 1977:

Hospital costs — 194%

Legal fees — 220%

Postal fees — 226% (If you like the way the U.S. Post Office is run, you'll love National Health Insurance.)

Budget for the Department of Health, Education, and Welfare — 364% (This is the bureau that will be in charge of any form of National Health Insurance.)

Federal budget — 400% (To curb inflation, the administration must open its eyes to this figure.)

Cost of running Congress — 442% (This is the same group of lawmakers that will pass the National Health Insurance bills and the administration's hospital "CAP" bill.)

Just ask yourself, why? Now that the record is straight, don't sit on it — work on it!

I wish each of you and your patients a happy and healthy New Year.

Sincerely,

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

New Members

Babaliaros, Constantine N., MAA—ACT—GS
1203 Cleveland Ave., Ste. 1-B, East Point 30344

Bishko, Jay R., Hall—N-2—AN
2590 Cove Rd., Gainesville 30501

Branch, Clinton E. Jr., Hall—ACT—N
1220 Sherwood Park Dr., Gainesville 30501

Brown, Morris E., MAA—N-2—IM
100 Colony Square, 1175 Peachtree St., NE, Atlanta 30361

Burnett, Claude A. III, Crawford W. Long—N-2—OS
468 N. Milledge Ave., Athens 30601

Donnelly, Edwin H., MAA—N-2—OPH
2004 Peachtree Rd., NW, Atlanta 30309

Goldklang, Gerald A., MAA—N-2—IM/HEM
2550 Windy Hill Rd., Ste. 210, Marietta 30067

Hawk, Thomas H. Jr., Crawford W. Long—N-2—GS
740 Prince Ave., Athens 30601

Kelly, William S., Crawford W. Long—N-2—AN
Box 473, Jefferson 30549

Kjellstrom, William A., MAA—ACT—OBG
960 Johnson Ferry Rd., Ste. 515, Atlanta 30342

Lake, Frank G. III, Hall—ACT—TR
147 Overlook Dr., Gainesville 30501

Lumpkin, William H., Whitfield-Murray—N-2—GS
1 Starr Dr., Dalton 30720

Maffett, Michael E., MAA—ACT—IM
11050 Crabapple Rd., Ste. 109, Roswell 30075

Mohanty, Santosh K., Laurens—ACT—GS/TS
VA Medical Center, Dublin 31021

Morris, Clell V., Crawford W. Long—N-2—IM/N
1077 Baxter St., Athens 30601

Nair, Vimala P., MAA—ACT—P
2355 Bolton Rd., NW, Atlanta 30318

Raggio, John F., DeKalb—I&R—NS
Emory University Clinic, 1365 Clifton Rd., NE, Atlanta 30322

Robinson, Leslie B., Cobb—N-2—IM
2990 Kodiak Ct., Marietta 30062

Rottenberg, Howard A., MAA—ACT—U
4536 Chamblee-Dunwoody Rd., Atlanta 30338

Scoggins, Bernard P., Dougherty—N-2—IM
2024 Health Care Center, Apt. 2, Leesburg 31763

Smith, Henry M., Crawford W. Long—N-2—N
1077 Baxter St., Athens 30601

Taylor, Gerald J., Sumter—ACT—P
712 E. Forsyth, Americus 31709

Vanderyt, William J., DeKalb—N-2—ORS
1462 Montreal Rd., Ste. 114, Tucker 30084

Vasquez, Carlos H., Thomas Area—N-2—GP
930 Fourth St., SE, Cairo 31728

Walker, Beverly D., Dougherty—N-2—PD
616 Oglethorpe Blvd., Albany 31702

Wheatley, Joseph K., MAA—N-2—U
Emory University Clinic, 1365 Clifton Rd., NE, Atlanta 30322

White, Paul C. Jr., Dougherty—ACT—OS
1109 N. Jackson St., Albany 31701

Whited, Everest A., Whitfield-Murray—ACT—FP
Hamilton Memorial Hospital, Dalton 30720

PERSONALS

First District

The Brooklet City Council sponsored a reception for **C. Emory Bohler, M.D.,** at the First Baptist Church of Brooklet. Mayor Harry Jones presented Dr. Bohler with a plaque in token of the community's appreciation for his 25 years of service.

June Blakely Jennings, M.D., director of laboratories, Costal Empire Pathology Services in the Memorial Medical Center, Savannah, has been elected to the board of directors of the American Society of Clinical Pathologists.

The Georgia Academy of Family Physicians has named **Andrew Joseph Yates Jr., M.D.,** of Soperton, as First District alternate director of the Academy. Dr. Yates' installation was held Nov. 9 in Atlanta as part of the Academy's Annual Scientific Session.

The members of the Toombs County Yeh Club honored cardiovascular surgeon, **Thomas J. Yeh, M.D.,** of Savannah, with a luncheon and the presentation of a plaque at the Vidalia Country Club, Saturday, Oct. 13.

Second District

Charles Gillespie, M.D., of Albany, spoke before a state legislative committee, Nov. 6, to propose legislation

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

APPLICATIONS ACCEPTED FOR MINI-FELLOWSHIPS IN EPILEPSY AND RELATED NEUROLOGICAL DISORDERS

The Georgia Comprehensive Epilepsy Program (CEP) is offering a 3 to 5 day mini-fellowship in epilepsy and related neurologic disorders. Participants will attend clinics, ward rounds, and conferences conducted by the Neurology Department at the Medical College of Georgia (MCG). The time will include participation in electronic monitoring of seizure activity in the Diagnostic and Treatment Unit for Epilepsy (DTU). Travel to and from Augusta and living expenses will be paid by the CEP. In special cases, an additional small stipend will be awarded. Preference will be given to physicians in private practice of family medicine or pediatrics. Dates for the fellowship will be arranged between Dr. Joseph Green and the applicant.

Those interested should contact: Joseph B. Green, M.D., or Thomas Casaday, Department of Neurology, MCG, Augusta, GA 30912. PH: (404) 828-4581.

MCG is an Equal Opportunity Educational Institution

mandating cardio-pulmonary resuscitation courses be taught to Georgia school children.

Fourth District

Robert M. Fine, M.D., Decatur, was recently elected Chairman-elect of the Dermatological Section of the Southern Medical Association at their recent annual meeting in Las Vegas.

Fifth District

Saint Joseph's Hospital has announced the new Chief-of-Staff, **Napier Burson, M.D.** He succeeds retired Chief-of-Staff William Friedewald.

Edwin C. Evans, M.D., of Atlanta was elected First Vice-President of the Southern Medical Association for 1979-80 during its 73rd Annual Scientific Assembly in Las Vegas.

Julian Jacobs, M.D., Atlanta, was recently certified as a Diplomate in hematology and internal medicine and is a Fellow of the American College of Physicians.

The Emory University School of Medicine officially named the Mason I. Lowance Chair of Allergy and Immunology during a special ceremony November 16. The chair honors Dr. Mason Lowance, an Atlanta physician and graduate of Emory Medical School, who has practiced allergy and immunology for several years.

Victor E. Silverman, M.D., Atlanta, has been certified as a Diplomate in the Subspecialty of Endocrinology and Metabolism, American Board of Internal Medicine.

Howard S. Yager, M.D., has been named a Fellow of the American Academy of Family Physicians.

Seventh District

Joseph G. Bussey, M.D., of Austell, was a featured speaker at the Professional Pain Management Seminar held in Atlanta recently.

J. Tom Cooper, M.D., Marietta, was recently elected a Fellow of the American Society of Bariatric Physicians.

Harry Eugene Dawson Jr., M.D., Rome, was recently named a Fellow of the American College of Surgeons.

Mark M. Lindsey, M.D., of Marietta, received the James D. Mills Meritorious Service Award, a tribute for exemplary leadership ability and service to the American College of Emergency Physicians. The award was presented at the MAG 1979 Scientific Assembly, Nov. 16-18.

D. Scott MacLeod, M.D., F.A.C.C., has been elected to a three-year term to the Georgia affiliate of the American Heart Association's state board of directors. He was installed during the Association's 31st Annual Meeting and Scientific Sessions at Callaway Gardens.

Toby Scott Morgan Jr., M.D., of Rome, was recently elected a Fellow of the American College of Surgeons.

Eighth District

The Hospital Authority of the Glynn-Brunswick Memorial Medical Hospital has appointed **Irwin Berman, M.D.,** St. Simons Island, to the medical staff.

Neurosurgeon, **Fleming L. Jolley, M.D.,** St. Simons Island, is also a newcomer to the Glynn-Brunswick Memorial Medical Hospital.

Ninth District

B. J. Davis, M.D., of Hartwell, has recently been

named a Diplomate of the American Board of Family Practice.

P. K. Dixon, M.D., Gainesville, was recently elected to a three-year term on the Board of Governors of Hospital Corporation of America (HCA).

Ronald Edward Eith, M.D., Gainesville, has opened an allergy practice in Gainesville.

Cassandra Brown Evans, M.D., has been named the director of the emergency room at the R. T. Jones Memorial Hospital in Canton.

Leonard Fishman, M.D., of Atlanta, has opened a dermatology practice in Habersham County.

The Chicopee Company recently honored **Walter Raleigh Garner, M.D.,** Gainesville with a luncheon to celebrate his 50th anniversary with the company.

Dave Westfall, M.D., has been named one of the explorer post advisors for the Lanier Park Hospital medical explorer program. The program is designed for young persons aged 15-20 to become acquainted with various medical fields.

Tenth District

James E. Baugh, M.D., was elected mayor of Milledgeville Wednesday, Oct. 31. He will serve the two years remaining on the unexpired term of the former mayor.

Charles R. Hatcher Jr., M.D., Atlanta, the American College of Cardiology (ACC) Governor for Georgia, announced Nov. 6 that **James W. Holsinger Jr., M.D., Ph.D.,** of Augusta, has achieved the rank of Fellowship.

Rodman Lemon Jr., M.D., of Augusta, has been named a Fellow in the American College of Surgeons.

C. Rex Teeslink, M.D., of the Medical College of Georgia in Augusta, has been appointed councilor-elect from Georgia to the Southern Medical Association (SMA). Dr. Teeslink began his five-year term at the close of the SMA's 73rd annual Scientific Assembly in Las Vegas.

SOCIETIES

The **Hall County Medical Society** met with officials of the Georgia Department of Medical Assistance (DMA) on Tuesday, Nov. 6 at the Brenau Nursing School Auditorium. Mr. Tip Carey, deputy director of DMA, was present to discuss doctors' problems with the Medicaid program.

The **Muscogee County Medical Society** took part in a free public seminar on "Miracle Drugs — The Blessing and the Curse." It was jointly sponsored by the Society, the Medical Center of Central Georgia, and the *Columbus Enquirer and Ledger*. Panelists included C. Daniell Cabaniss, M.D., Moderator, and Richard Robbins, M.D.

The members of the **Whitfield-Murray County Medical Society** heard William Moore, M.D., of Atlanta, at their November meeting. Dr. Moore presented a talk on medical ethics and also presented information relating to professional liability insurance. Also present at the meeting was Tom Sawyer, Assistant Executive Director of MAG.

DEATHS

George A. Holloway

George A. Holloway, M.D., 73, died Sunday, Oct. 28, 1979.

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Keogh— to prepare for the years ahead.

Keogh at Fulton Federal is a retirement plan for the self-employed. It allows you to contribute 15% of your earned income, up to $7500 per year, and defer taxes on your deposits, until you retire.

If you already have a Keogh Account, please note that contributions can be made as late as the tax filing deadline, including extensions.

To find out more, call Fulton Federal's Retirement Plan Counselors at (404) 586-7031. Keogh— it's the way to prepare for the years ahead, starting today.

EQUAL HOUSING LENDER

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 Atlanta, Georgia 30301 404-586-7283

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

WELCOME

The
Medical Arts
Motel

5000 WATERS AVENUE
SAVANNAH, GEORGIA 31404

Savannah's Convenient Motel
"The Best for Less"

For Reservations
CALL 912-354-9710

Located near Memorial Medical Center
and Medical Arts Shopping Center

Mrs. A. M. White
General Manager

Dr. Holloway was a graduate of Oglethorpe University and the University of Georgia Medical College in Augusta. He was a U.S. Navy veteran of World War II during which he served as a lieutenant commander. He practiced medicine in Atlanta for over 40 years and was a former chief of obstetrics and gynecology at Piedmont Hospital.

Survivors include his wife, two daughters, a son, a sister, and two brothers.

Norberto Alejandro Fontana

Norberto Alejandro Fontana, M.D., 52, died Tuesday, Oct. 30, 1979.

Dr. Fontana was a native of La Pampa, Argentina. He received his medical degree from Buenos Aires University in Argentina and then came to the United States in 1957 to acquire additional training at a hospital in Danbury, Connecticut. He became a U.S. citizen in July 1968. He participated in a rotating internship at McKinley Hospital in Trenton, New Jersey, and completed his residency in general practice at Herbert Thomas General Hospital, West Virginia, before coming to Thomasville. He served as an emergency room physician at the Archbold Memorial Hospital from 1972 until his death.

Survivors include his wife.



Theme for National Volunteer Blood Donor Month . . . and for the future.



Tagamet®

brand of

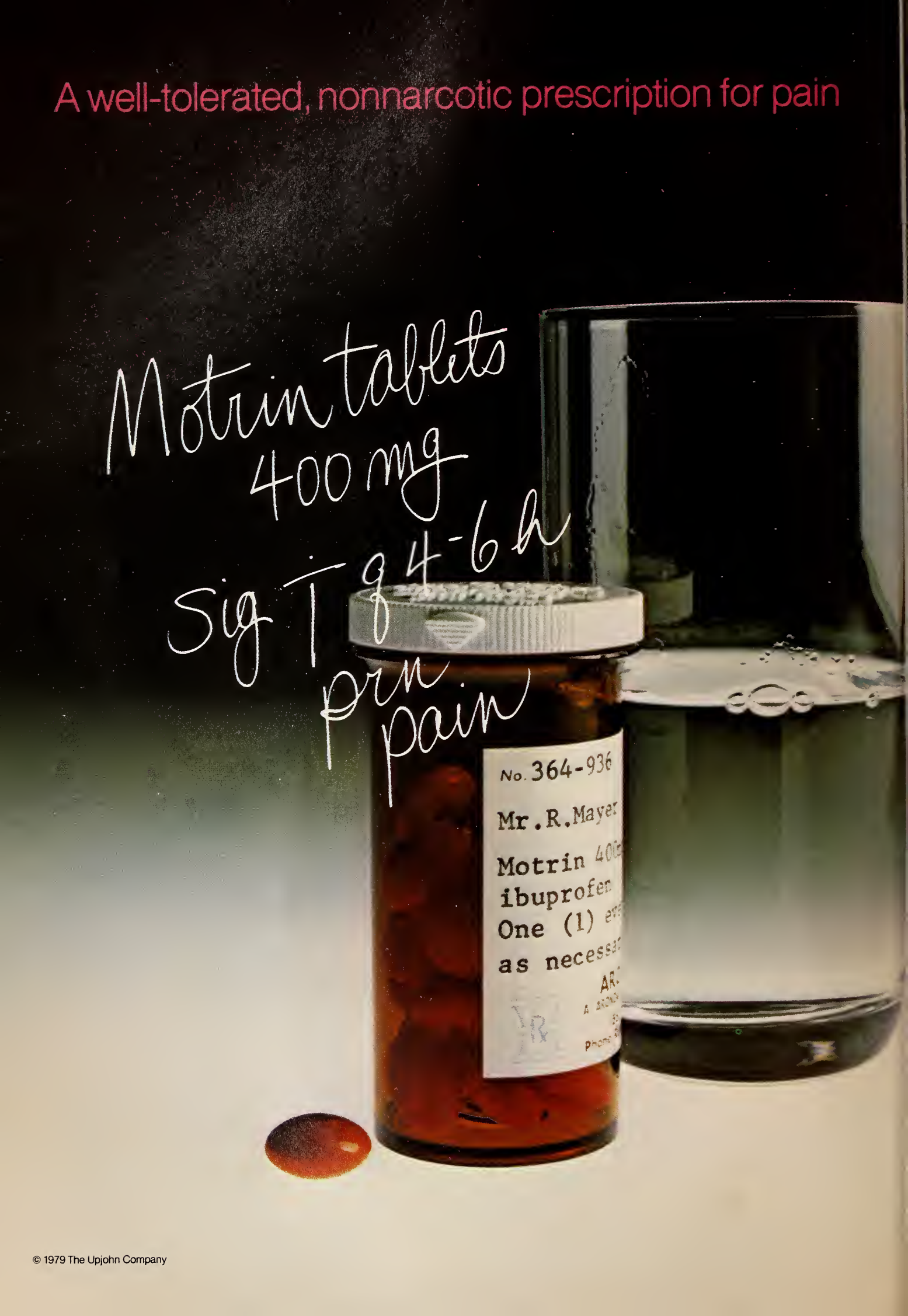
cimetidine

How Supplied:

Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

SK&F LAB CO.
a SmithKline company

A well-tolerated, nonnarcotic prescription for pain



© 1979 The Upjohn Company

Motrin® now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400 mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

MED B-4-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

Remember

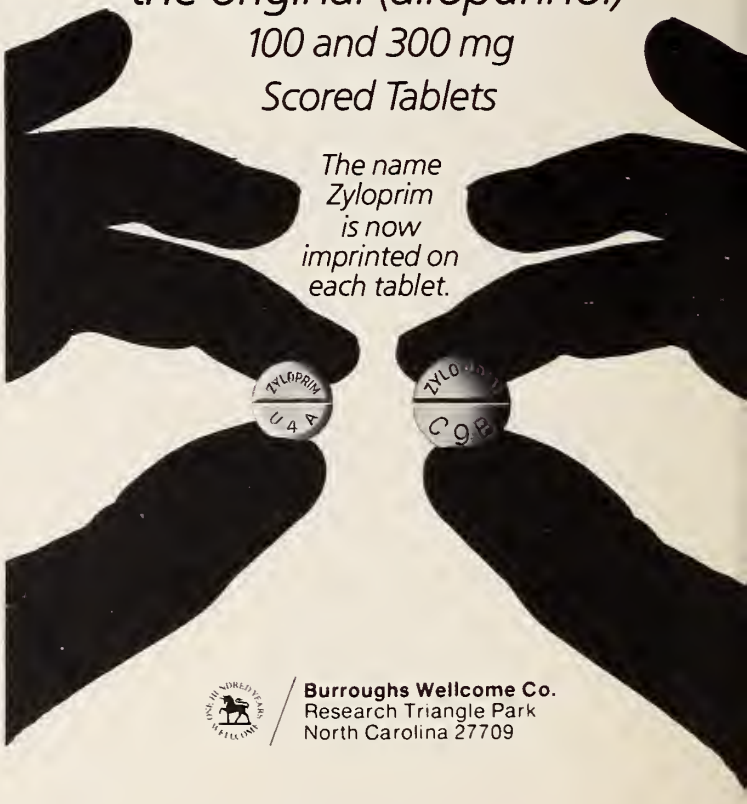
ZYLOPRIM®

the original (allopurinol)

100 and 300 mg

Scored Tablets

The name Zyloprim is now imprinted on each tablet.

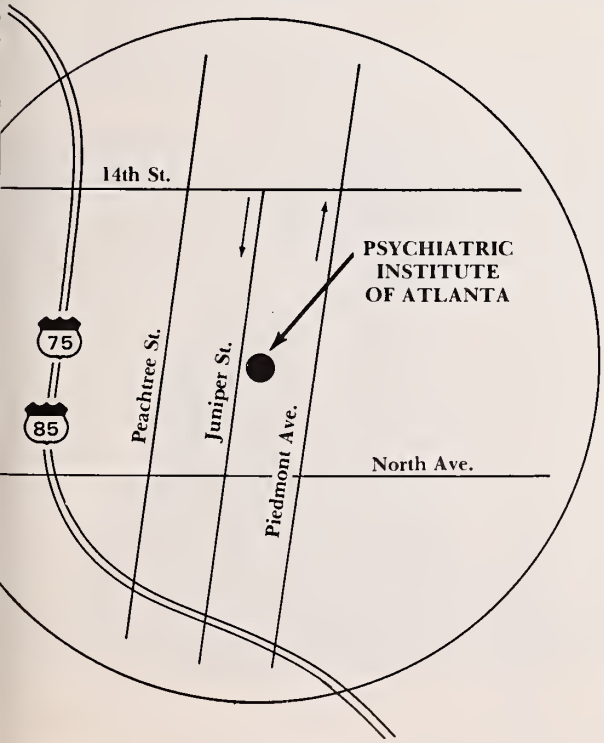


Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Specialized Health Care In the Heart of Atlanta



Psychiatric Institute of Atlanta



- Emergency care and crisis intervention service
- Alcohol and drug detoxification service
- Adult inpatient treatment
- Family counseling
- Diagnostic screening and evaluation
- Vocational rehabilitation counseling
- Community liaison and consultation
- Biofeedback and behavior modification training
- Psychological testing

811 Juniper Street, N.E., Atlanta, Ga. 30308 Tel: 404/873-6151

The 1979 MAG Scientific Assembly

In a day when competition among medical meetings is getting stiffer, MAG's relatively new fall Scientific Assembly is showing remarkable signs of success. Attendance at this year's Assembly, held November 15-18 at Atlanta's Omni International Hotel, was 943 — an increase of over 50 from the previous high for an independent MAG meeting. Included in the attendance figure are 518 MAG members who paid a registration fee and many other nonpaying members who were program chairmen or speakers.

Chairman of the 1979 Scientific Assembly was Mark M. Lindsey, M.D., an emergency room physician from Atlanta.

The program included simultaneous scientific sessions in sixteen specialties, with nineteen state and local specialty societies doing the planning. This pioneering format has become a model for other states. It allows for interchange among the many diverse segments of organized medicine and demonstrates the unity of the profession on the value of continuing education.

The 1979 Calhoun Lecturer was Edmund D. Pellegrino, M.D., President of the Catholic University of America in Washington, D.C., whose address, "Medical Economics and Medical Ethics — the Growing Conflict," was very well received. The lecture will be printed in an upcoming issue of the *Journal*. An MAG reception followed the lecture.

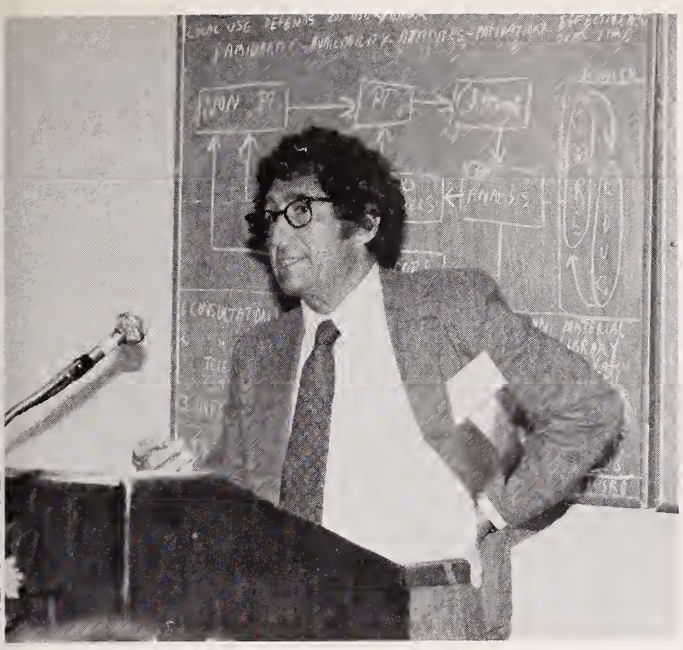
Two special educational programs were featured at this year's Assembly. The Georgia Chapter of the American College of Physicians, in cooperation with the Georgia Health Sciences Library Association, sponsored a seminar on "Recent Advances in Medical Information Transfer and Technology." The seminar drew 100 physicians and medical librarians



Lionel M. Bernstein, M.D., F.A.C.P., comments on new techniques for information transfer. Dr. Bernstein is the director of the Lister Hill National Center for Biomedical Communications, National Library of Medicine, Bethesda, Maryland.



Edward J. Huth, M.D., F.A.C.P., Editor of the *Annals of Internal Medicine*, Philadelphia, addresses the subject, "Is There a Future for Medical Journals?"



Associate Dean for Continuing Education and Associate Professor of Medicine from Tufts University School of Medicine, Boston, Norman S. Stearns, M.D., F.A.C.P., discusses the use of data banks and journals in continuing medical education.

for a discussion of the role of technology, clinical data banks, and medical journals in continuing medical education.

The four medical schools in Georgia and the MAG's Committee on Education sponsored a Conference on Medical Education, the first such statewide conference since 1976. Participants heard



Fairfield Goodale, M.D. (Second from right), Dean of the Medical College of Georgia (MCG) responds to a question at the conference on medical education. Others with him are (L-R) Lois T. Ellison, M.D., Provost, MCG; Louis Sullivan, M.D., Dean of Morehouse College School of Medicine; and John Harries, M.D., Dean of Mercer University School of Medicine.

the deans describe the priorities and philosophies of medical education at their respective schools and then heard MAG President Earnest Atkins, M.D., address the topic of the MAG's goals and priorities. The Scientific Assembly appeared to be a good occasion for the conference.

MAG's 1980 Scientific Assembly is planned for November 21-23, again at the Omni International Hotel in downtown Atlanta. The chairman will be Arthur J. Merrill Jr., M.D., an internist from Atlanta.

(Reported by Stephen L. Daniel, Ph.D., MAG's Assistant Executive Director – Education.)

TEGA-CODE TABLETS C-111

ANALGESIC - ANTIPYRETIC - SEDATIVE

Each tablet contains:

Acetaminophen	300 mg.
Salicylamide	200 mg.
*Sodium Pentobarbital (derivative of barbituric acid)	10 mg.
*Codeine Phosphate	(½gr.) 32.4 mg.

***WARNING: May be habit forming.**

Action: Combination of analgesic and antipyretic with sedative.
Indications: Indicated in cases of severe pains, especially when associated with tension, pains and discomforts of neuralgia, rheumatism and arthritis.
Precaution: Use with caution in persons with known allergies to salicylates and barbiturates and in those with active peptic ulcer.
Warning: Long administration may cause habituation.
Side Effects: Large doses may cause nausea, vomiting, skin rash and sometimes anaphylactic reactions.
Contraindications: Idiosyncrasy to any component.
Supplied: Available in bottles of 100 and 1000.
Dose: Adults, one tablet 3-4 times daily, as directed by a physician.

CAUTION: Federal Law prohibits dispensing without prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from July 23-November 28, 1979.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Randel Sease Abrams, Moody AFB
Morgan Charles Adair, Rome
William Earl Adams, Columbus
Arjandas L. Ahuja, Thomasville
Ricardo B. Akstein, Atlanta
Stanley Preston Aldridge, Decatur
Jose Gilberto Alfonso, Valdosta
Hyman Alford, Columbus
Robert Jay Alpern, Smyrna
Manuel P. Anton, Decatur
Arcot D. Ashok Kumar, Columbus
Stephen Peter Auda, Riverdale
Richard Alan Bardack, Marietta
Joseph Donald Bartley, Columbus
Noah Samuel Bass, Atlanta
Paul Everett Beecham, Roswell
Charles Bacon Bell, Decatur
Bernard A. Bergman, Smyrna
Irwin Ralph Berman, Brunswick
John Franklin Bigger, Augusta
Farouk Joseph Blell, Savannah
Joseph Aldean Blissit, McDonough
Augustus F. Bloodworth, Gainesville
Robert Martin Boger, Decatur
Donald Lee Boyd, Albany
Stephen Boyle, Conyers
Paul Lewis Bradley, Dalton
James Willie Branam, Statesboro
Henry Aimar Brandt, Savannah
Marvin Anthony Brantley, Atlanta
Richard Lance Brown, Atlanta
Howard Leon Bruckner, Augusta
John Knox Burns, Gainesville
Calvin Leonard Butts, Savannah
William Chapman Butz, Decatur
Horatio V. Cabasares, Macon
George Muller Callaway, Decatur
Raymond Vincent Caputo, Atlanta
Albert W. Carter, Forest Park
Henry R. C. Chalmers, Atlanta
Barbara K. Chang-Wai-Ling, Augusta
Alice K. G. Chelton, Atlanta
Luis M. Colon, Milledgeville
William C. Conner, Decatur
Floyd Childs Cooper, Griffin
Leonard Leroy Cotts, Atlanta
John Russell Curtis, Athens
William Gibson Cutts, Canton
Dave McAlister Davis, Atlanta
Henry G. Davis, Sylvester
Jose Arturo Delgado, Milledgeville
Julio Valentino Denning, Augusta
Jimmy Lenon Dixon, Brunswick
William Anthony Dodd, Sea Island
Maurice Dunn, Augusta
Maxwell Armand Eidex, Decatur
John Eliades, Fort Benning
Dean Cook Elliott, Augusta
Gary Richard Ellis, Valdosta
Ilhan Ermutlu, Decatur
Gerson Zarsadiaz Escondo, Columbus
Ben Norris Estes, Augusta
Lawrence Allan Fagarason, Fort Benning
Michael B. Feinerman, Austell
Richard Emerson Felder, Atlanta
James Paul Ferguson, Rome
Marion Lynn Ferrell, Sparta
David Benton Fillingim, Savannah
John Marion Fillingim, Savannah
Francis J. Flanagan, Dublin
William Chester Ford, Lavonia
Lawrence Lee Freeman, Chamblee
Leroy Robert Fullerton, Ft. Benning
Thomas Earle Fulmer, Atlanta
Henry Gall, Cairo
Carmen Gannon, Savannah
Edwin Steven Gerson, Riverdale
James Samuel Goodlet, Marietta
Samuel Melvin Goodrich, Milledgeville
Gary Philip Greenhood, Marietta
John Bunyan Griffin, Atlanta
William George Grubb, Brunswick
Margaret Frank Guill, Augusta
Melvin Lawrence Haas, Augusta
Boaz Harris, Atlanta
Gary Noel Harrison, Augusta
Steven John Harwood, Augusta
Theodore R. Hatfield, West Point
George Seaborn Heath, Waycross
Kenneth C. Henderson, Macon
Bansilal M. Hirani, Milledgeville
James W. Holsinger, Augusta
Robert Walton Horseman, Evans
William Burke Hotalen, Marietta
William Slocum Howland, Atlanta
James Bonothoe Hurst, Milledgeville
Charles R. Ireland, Macon
Jack Reynolds Jarvis, Decatur
Jane Blakely Jennings, Savannah
Clarence M. Johnson, St. Simons Island
Gustaf Hugo Johnson, Savannah
Julius T. Johnson, Augusta
Kenneth Douglas Jones, Augusta
Joel Kahan, Augusta
Dorothy Karandanis, Atlanta
Clifton G. Kemper, Atlanta
Thomas Eugene Kennedy, Buford
William Knox Kinlaw, Decatur
Costas Kleanthous, Fort Benning
Jonathan Seth Krauss, Augusta
Gopa K. Kumar, Quitman
Leonard Perry LaConte, Moultrie
Charles C. Lamb, Albany
Stephen John Lange, Savannah
Henry LaSalle, Covington
Stephen Sek-King Law, Marietta
Ian Irving Lipsitch, Atlanta
Eugene Mitchell Long, Augusta
Grady Estes Longino, Dublin
Cesar Antonio Lopez, Fort Benning
James Lee Mason, Atlanta
Richard C. Mattison, Atlanta
Sean Francis McCue, Augusta
Archibald A. McNeill, Camilla
John H. T. McPherson, Athens
Jack Reeves Meacham, Summerville
Jonathan Ray Merrill, Atlanta
Christian Lee Merz, Decatur
James Clayton Metts, Cumming
Robert Dempsey Milledge, Atlanta
Shannon Mize, Cumming
Palghat V. Mohan, Dublin
Milagros Montesclaros, Fort Benning
Steven Curtis Moreland, Atlanta
Salah Nasrallah, Atlanta
Marshall David Nathan, Augusta
Bruce Cameron Newsom, Columbus
W. Lanier Nicholson, Hiawassee
John Henry Nolen, Marietta
Carlos Ordonez, Dunwoody
Ui Ho Park, Dublin
Willie Morrow Patterson, Martinez
Francis Moore Patton, Newnan
Juan A. Perez-Enriquez, Milledgeville
Paul Raymond Phelps, Macon
Alan Lane Plummer, Atlanta
Zane Franklin Pollard, Atlanta
Glenn Noel Pomerance, Columbus
Geoffrey M. Posner, Norcross
Martin Stanley Pritzker, Savannah
Robert A. Pumpelly, Jesup
Jack A. Raines, Columbus
Joseph Stuart Randall, Atlanta

James Peter Reitt, Atlanta
John Peter Rissing, Augusta
Harrison L. Rogers, Atlanta
Stephen Daniel Rossner, Atlanta
Ralph Emerson Roughton, Atlanta
Gil Domingo Saguiguit, Moody AFB
Philip Bryan Sapp, Dalton
Charles Eliot Sax, Savannah
William Michael Scaljon, Atlanta
Donald W. Schmidt, Cedartown
Steven M. Schneiderman, Decatur
Robert Orville Schoffstall, Macon
Robert Samuel Shacklett, Thomaston
Jyoti Ramesh Shah, Dublin
Wayne Chris Sheils, Columbus
Webster Armour Sherrer, Canton
Ivy Lee Shuman, Sylvania
George Brook Skipworth, Columbus
Sidney Dion Smith, Atlanta
Joseph Carroll Souther, Winder
Dennis Lee Spangler, Atlanta
Jean Stewart Staton, Decatur
William Alexander Steed, Augusta
David Joseph Steger, Columbus
John Edward Steinhaus, Atlanta
Joseph McCain Still, Augusta
James L. Story, Thomasville
Yung-Fong Sung, Atlanta
Elmo Roldan Tamayo, Chatsworth
Bruce Lee Tanenbaum, Augusta
Rene Alberto Tapia, Decatur
Corbett H. Thigpen, Augusta
Jack A. Thompson, Atlanta
Don Warren Turner, Atlanta
Joseph Murray Turner, Tifton
Karkada Jayarama Upadhya, Dublin
Charles Bell Upshaw, Atlanta
Briccio Dizon Valdez, Columbus
Carlos Humberto Vasquez, Cairo
Anthony Joseph Vinciquerra, Augusta
David Carroll Waggoner, Atlanta
Lawrence L. Washburn, Atlanta
Donald Brent Waters, Blackshear
Jay Stanley Weisfeld, Atlanta
John Alfred Wells, Macon
Mary E. Miller Wiles, Atlanta
William Augustus Williams, Macon
Isaac Willis, Atlanta
Benjamin Charles Wills, Savannah
Fremont Philip Wirth, Savannah

Dr. David McClusky Receives American College of Surgeons' Award

The Georgia Chapter of the American College of Surgeons sponsored an annual Residents' Competition for presentation of scientific papers in conjunction with MAG's Scientific Assembly at the Omni International Hotel in Atlanta on November 17, 1979. First prize was awarded to Dr. David McCluskey of the Georgia Baptist Medical Center and included a check for $200. Judging the competition were Drs. Marion Anderson of Charleston, South Carolina; C. Gardner Child III, of Atlanta; Harold Engler of Augusta; and T. Gray Fountain of Albany. The winning paper was entitled "CPA/OPG Testing vs. Arteriography — Is Noninvasive Testing of Benefit?"

1980 MAG Practice Management Workshops

in cooperation with Department of Practice Management, American Medical Association

TEAM BUILDING — A BETTER WAY TO SUPERVISE

— workshop for medical office managers —

Tuesday, February 12, 1980
Ramada Inn Central, Atlanta

The seminar will cover recruiting, interviewing, and selecting employees; developing meaningful job descriptions and personnel policy handbook; motivating and coaching employees to be "key players"; job performance review, terminating an employee, and salary review; and better communication through effective staff meetings and training. This workshop is designed for persons who are presently in a supervisory or management position. It is not for *non-supervisors*.

Registration fee is $50 per person. Enrollment limited to first 35 registrants.

STARTING YOUR PRACTICE

— workshop for residents —

February 13-14, 1980
March 12-13, 1980
Ramada Inn Central, Atlanta

This workshop is designed for young physicians planning to enter private practice and covers paperwork, patient management and public relations, personnel, physical characteristics of a medical office, "where and how," and legal problems.

Registration fee is $125 for members of a medical society; $95 for non-members. Spouses may audit at no charge (except $11 luncheon fee). Enrollment limited to first 25 registrants.

For further information and registration forms,
Contact MAG's Division of Education, 876-7535 or (toll free) 800-282-0224

Index to Advertising

Vol. 69 JANUARY 1980 No. 1

American Holistic Medical Association 18
American Red Cross 58
Arthritis Foundation 26
Ballard, Walter, Optical Company 58
Brawner Psychiatric Institute 4
Burroughs Wellcome Company 12, 62
Classified Advertising 69
Diacon System 46
Dickey-Mangham Company 57
Fulton Federal Savings and Loan Association 57
Global Imports 3
The Great Cherokee Trading Company 18
Kaplan, Stanley, Educational Center 18
Lilly, Eli, and Company 15
MAG Practice Management Workshop 67
The Medical Arts Motel 58
Medical Buildings and Equipment, Inc. 3
Medical College of Georgia 56
Merck, Sharp, & Dohme 20, 21, 22
The Morrill House 6
Office Communications, Inc. 51
Ortega Pharmaceutical Company, Inc. 65
Peachford Hospital 52, 53
Peachtree and Parkwood Mental Health Center and Hospitals 70
Potter-Holden and Company 18
Psychiatric Institute of Atlanta 63
Roche Laboratories 2, 71, 72
Smith, Kline, & French 59
The Upjohn Company 60, 61, 62
United Way 36, 38
Valley Psychiatric Hospital 25
Weight Watchers of Greater Atlanta 56
Willingway Hospital 33
Wyeth Laboratories 39, 40, 41, 42

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$10.00 for the first 50 words; $.15 per word for each additional word. **Non-members**—$20.00 for the first 50 words; $.20 per word for each additional word. *Charges are payable in advance*. Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535, INWATS in Georgia (800) 282-0224.

PHYSICIANS WANTED

PEDIATRICIAN — Opening to share a pediatric clinic with pediatrician in practice for 18 years in Savannah, Georgia (5 years as an instructor, 11 years as Director of Pediatrics at Memorial Medical Center and 2 years of private practice). Excellent location near residential area and new private hospital. Good professional opportunity in rapidly growing area. Phone: (912) 355-9519 after 8:00 p.m., or write: Pediatrician, P.O. Box 13542, Savannah, GA 31406.

BOARD CERTIFIED INTERNIST with 5 to 10 years' experience to act as consultant and advisor for large corporation (Atlanta office). Approximately ½ day per week to start. Please send personal resume to Box 1-A c/o the *Journal*. All replies will be answered and held in strict confidence. Equal Opportunity Employer.

EMERGENCY PHYSICIAN — Progressive 246-bed JCAH hospital has position available for staff physician. Prefer physicians who have completed residency program in emergency medicine or primary care specialty, or who have experience. U.S. graduates only. Excellent specialty staff support. Beautiful location, outstanding recreational opportunities including hunting, fishing, tennis, golf, and water sports. Fee-for-service with present median income for staff physicians at $65,000-$70,000. Please respond with a complete CV to: Box 1-B, c/o the *Journal*.

OB-GYN DIRECTOR — Opening for Director of Residency Training Program in OB-GYN in Pensacola Educational Program, Pensacola, Florida for Board-certified or Board-eligible physician. Total program of 6 different residencies associated with 4 different hospitals in community-based educational program. Salary competitive with excellent fringe benefits of paid vacation, liability insurance, health and disability insurance, paid educational and professional trips. OB program affiliated with Tulane. Gulf coast living at its best, and health care in area of over ¼ million. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education, (904) 477-4956, or send C.V. to Director of Medical Education, Pensacola Educational Program, Ste. 307, 5149 N. Ninth Ave., Pensacola, FL 32504.

SITUATIONS WANTED

ANESTHESIOLOGIST RELOCATING. All types of anesthesia including obstetrical, open heart. Prefer group. Can work with CRNAS. Available immediately. Subbarao Narepalem, M.D., 5219 W. 52nd St., Cleveland, OH 44134.

CARDIOLOGIST INTERNIST, 31, ABIM certified, university trained invasive and noninvasive cardiology. Seeks solo or associateship. Available July 1980. Contact: George B. Ghanem, M.D., 39030 Pinebrook, Sterling Heights, MI 48078. (313) 979-2848.

FOR RENT

MEDICAL OFFICE SPACE AVAILABLE, contiguous to established internal medicine group. 705 Concord Rd., Smyrna, GA. Call: 432-9000.

WEST MARIETTA PROFESSIONAL BLDG., Powder Springs Rd. Medical and dental suites available. Rent with option to buy. Call AFTCO Associates, (404) 992-5632.

SERVICES

DOCTORS FINANCIAL SERVICES — Do you need money? We can help secure the funds you need. Virtually unlimited capital is available for debt consolidation, expansion, investments, taxes, tuition, or any purpose. All transactions confidential. Contact: Financial Resources Ltd., (404) 992-1268, Gregory M. Kingsbury, Consultant.

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and er phasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internis is available to meet the medical needs of a patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscop X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

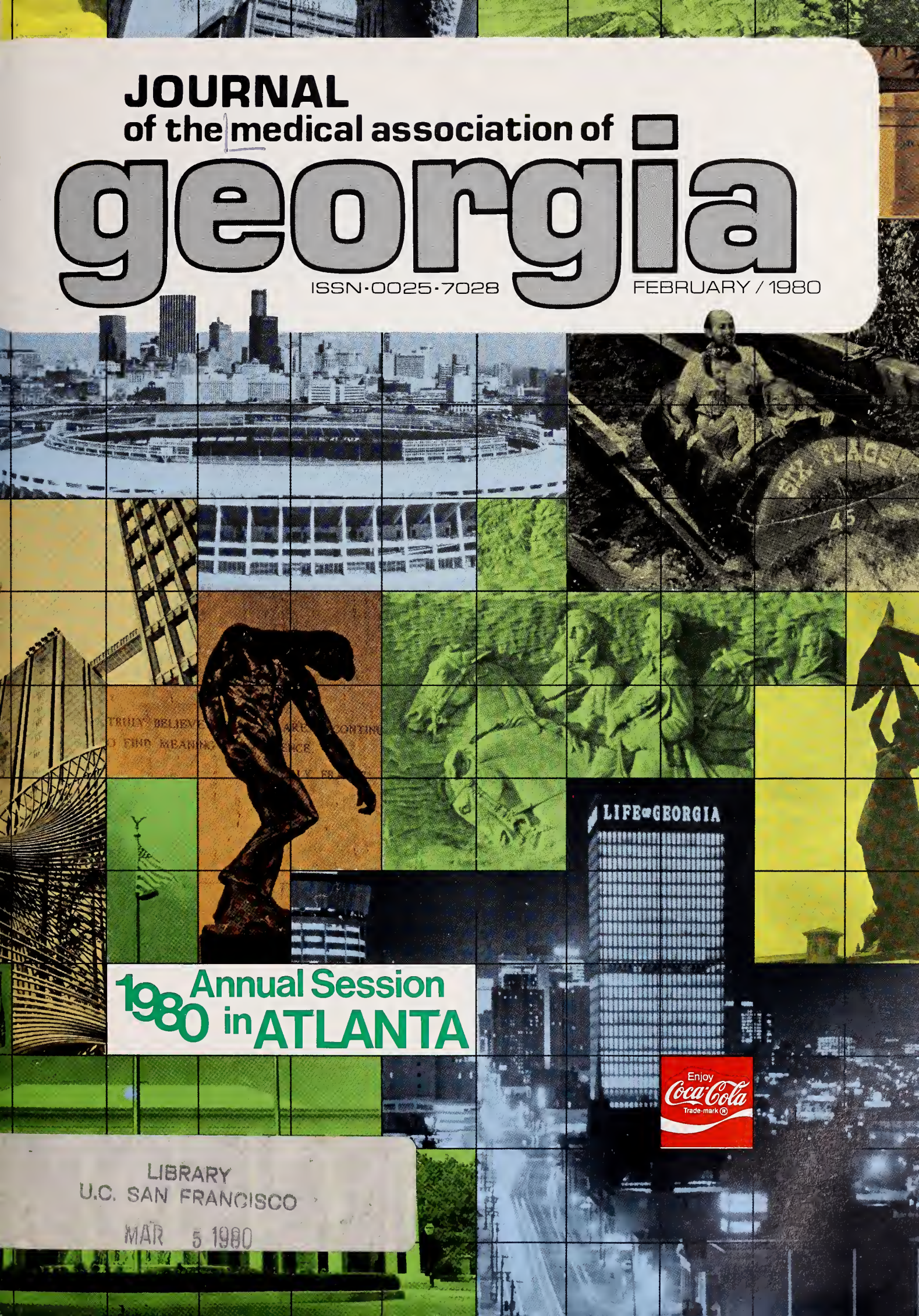
Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

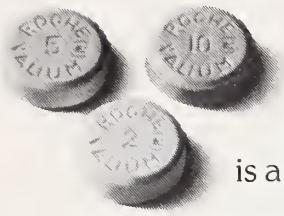
JOURNAL
of the medical association of
georgia
ISSN·0025·7028 FEBRUARY / 1980



1980 Annual Session in ATLANTA

LIBRARY
U.C. SAN FRANCISCO
MAR 5 1980

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

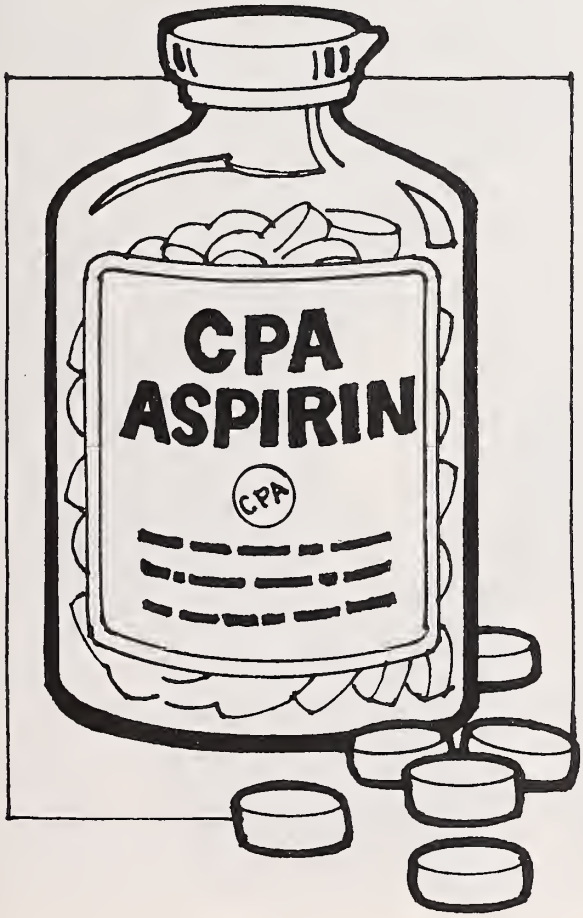
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

how do others avoid tax headaches? your CPA knows!



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

Ask a CPA, and be sure

CPA

Georgia Society of Certified Public Accountants

6404



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

JOURNAL
of the medical association of georgia

contents

VOLUME 69, NUMBER 2

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

ADVERTISING REPRESENTATIVE
Mary Coté

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Peter L. Scardino, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/ EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Earnest C. Atkins, M.D., Atlanta
President
H. Hilt Hammett Jr., M.D., La Grange
President-Elect
Carson B. Burgstiner, M.D., Savannah
Immediate Past President
Richard A. Griffin III, M.D., Cartersville
First Vice President
S. W. Clark, M.D., Waycross
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Stephen L. Daniel, Ph.D., Assistant Executive Director — Education
J. Tom Sawyer, Assistant Executive Director — Administration
Rusty Kidd, Director of Legislative Activities
Kenneth M. Williams, Director of Public and Professional Relations
Joyce Butler, R.N., Director of Medical Practice
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The Journal of the Medical Association of Georgia is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

THE 126TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

91 General Information
92 Introducing Hoyt D. Gardner, M.D., as Guest Speaker
93 Officers of the Association
94 Component County Society Representation to the 1980 House of Delegates
95 Criteria for Selection of Recipients of MAG Awards
96 Directors and Delegates
98 Official Program

THE 55TH ANNUAL AUXILIARY CONVENTION

100 Greetings
101 1980 Auxiliary Annual Convention Schedule

SCIENTIFIC ARTICLES

109 Clinicopathological Conference
John F. Fisher, M.D.
Raghunatha Rao, M.D.
117 Viral Hepatitis Outbreaks — Georgia, Alabama
Center for Disease Control
118 Use of Eye Bank Sclera in Plastic and Reconstructive Surgery
Ralph E. Wesley, M.D.
Janie Benson
Clinton D. McCord Jr., M.D.
121 The Seriously Burned Adult: Psychologic Reactions, Recovery, and Management
C. David Tollison, Ph.D.
Joseph M. Still Jr., M.D.
Joseph W. Tollison, M.D.

SPECIAL ARTICLE

102 The Allure of Atlanta
Susan J. Dillon

EDITORIAL

125 Health Versus Radiation Hazard
Robert L. Egan, M.D.

FEATURES

127 Legal Page/Reconciling the Antitrust Laws and the Health Care Laws
Robert N. Berg
131 Heart Page/Vasodilator Therapy of Chronic Congestive Heart Failure
C. Daniel Cabaniss, M.D.
137 Cancer Page/Current Management of Nonseminomatous Testis Tumors
Thomas W. Schoborg, M.D.
A. P. Rodriguez, M.D.
Charles Scott Jr., M.D.
144 President's Letter/Too Many Cooks Can Spoil the Broth
Earnest C. Atkins, M.D.

THE ASSOCIATION

141 New Members
141 Personals
142 Rusty Kidd Promoted to New Position at MAG
143 Societies
143 Deaths

INCIDENTAL INTELLIGENCE

78 Medical Meeting Calendar
80 Of Special Interest . . . Congressman Writes MAG Member Re PSRO
80 Cobb County Annual Symposium — "You Are What You Think"
80 State Laboratory to Charge Fees for Service

COVER

There is much diversity in Atlanta as suggested by the montage on our cover. Notwithstanding trying times, as reported by some media at times, there is much that is beautiful in Atlanta, too, especially in the spring. Come to the Annual Session in April and experience another dimension of this great city as you participate in and contribute to medical politics in our state and nation. Photos Courtesy of the Atlanta Chamber of Commerce and the Atlanta Convention Visitors Bureau. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

MEDICAL MEETING CALENDAR

FEBRUARY

26—*Atlanta;* **FINANCIAL CONTROL FOR PHYSICIANS;** Contact: Conomikes Associates, Inc., 4270 Promenade Way, Marina del Rey, CA 90241. PH: 800/421-6512.

27-March 2—*New Orleans, LA;* **43RD ANNUAL NEW ORLEANS GRADUATE MEDICAL ASSEMBLY;** Category 1 credit; Contact: New Orleans Graduate Medical Assembly, Tulane Medical Center, 1430 Tulane Ave., New Orleans, LA 70112.

MARCH

1-8—*Steamboat Springs, CO;* **FIFTH ANNUAL SNOW JOB IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

4-7—*Durango, CO;* **EMERGENCY MEDICINE: THE ADULT AND THE CHILD;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

6-7—*Atlanta;* **RECENT ADVANCES IN THE MANAGEMENT OF THE LONG-TERM DIALYSIS PATIENT;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

16-19—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 credit; Contact: Winnie Hopkins, Medical Assn. of Atlanta, 875 W. Peachtree St. NW, Atlanta 30309. PH: 404/881-6128.

20-22—*Gainesville, FL;* **11TH ANNUAL TOPICS IN INTERNAL MEDICINE;** Category 1 credit; Contact: Bill Rockwood, Box J-233, JHM Health Center, Univ. of Fla. College of Med., Gainesville, FL 32610. PH: 904/392-3143.

20-27—*Atlanta;* **SPRING MEETING, AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS/COLLEGE OF AMERICAN PATHOLOGISTS;** Contact: American Society of Clinical Pathologists, 2100 W. Harrison St., Chicago, IL 60612. PH: 312/738-1336.

21-23—*Kiawah Island, SC;* **SOUTH CAROLINA REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS;** Category 1 credit; Contact: Clarence W. Legerton Jr., M.D., Medical University Hospital, Charleston, SC 29401.

23-27—*Toronto, Ontario;* **SPRING MEETING, AMERICAN COLLEGE OF SURGEONS;** Category 1 credit; Contact: C. Rollins Hanlon, M.D., ACS, 55 E. Erie St., Chicago, IL 60611.

27-28—*Chattanooga, TN;* **FIFTH ANNUAL PEDIATRIC SYMPOSIUM;** Contact: Dennis K. Wentz, M.D., Director of Continuing Education, Univ. of Tenn. Center for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

28—*Savannah;* **DAY OF CANCER;** Category 1 credit; Contact: Shirley Preston, American Cancer Society, Georgia Division, 1422 W. Peachtree St. NW, Atlanta 30309. PH: 404/892-0026.

28-29—*Atlanta;* **THE TREATMENT OF ARTHRITIS — UPDATE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

31-April 4; *Gainesville, FL;* **11TH FAMILY PRACTICE REVIEW;** Category 1 credit; Contact: Bill Rockwood, Box J-233, JHM Health Center, Univ. of Fla. College of Med., Gainesville, FL 32610. PH: 904/392-3143.

31-April 4; *Atlanta;* **CLINICAL CYTOPATHOLOGY;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

APRIL

1-4—*Augusta;* **CRITICAL CARE MEDICINE;** Contact: Gerald T. Chambers, M.D., Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

7-9—*Atlanta;* **GASTROENTEROLOGY FOR THE PEDIATRICIAN;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

10—*Atlanta;* **PSYCHOANALYTIC OBJECT-RELATIONS THEORY;** Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, 3400 Peachtree Rd. NE, Ste. 913, Atlanta 30326. PH: 404/266-2887.

10-12—*Atlanta;* **PHARMACOLOGY FOR THE ANESTHESIOLOGIST;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

10-12—*Atlanta;* **PERSPECTIVES IN SURGERY;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

11-12—*Atlanta;* **REPRODUCTIVE TRACT RECONSTRUCTIVE SURGERY;** Category 1 credit;Contact: Amir H. Ansari, M.D., Georgia Baptist Medical Center, 340 Boulevard NE, Ste. 641, Atlanta 30312. PH: 404-659-5211.

11-13—*Atlanta;* **FIFTH ANNUAL DOGWOOD CONFERENCE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

15-16—*Augusta;* **NEONATOLOGY;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

16-18—*Pine Mountain;* **SECOND ANNUAL PATIENT EDUCATION CONFERENCE;** Contact: Southeastern Institute for Community Health, P.O. Box 1708, LaGrange 30241. PH: 404/637-6646.

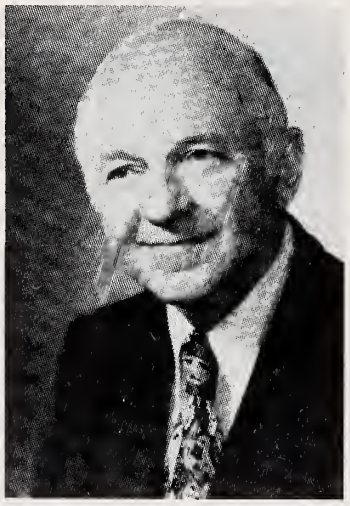
17-18—*Atlanta;* **TECHNIQUES COURSE AND MOTOR SKILLS WORKSHOP ON INTERNAL FIXATION OF FRACTURES;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

18-19—*Augusta;* **PREDICTIVE AND PREVENTIVE MEDICINE;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

28-30—*Atlanta;* **48TH ANNUAL ASSEMBLY, SOUTHEASTERN SURGICAL CONGRESS;** Category 1 credit; Contact: Southeastern Surgical Congress, 315 Boulevard NE, Ste. 500, Atlanta 30312. PH: 404/681-3733.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

medicard



I am proud to present the one card that increases your cash flow -- MEDICARD.

Whether your facility is a one person operation or a large health care group, we offer three day turnaround on your funds, less a minimal discount fee. In addition, we prepare tailor-made billing systems for your particular needs, and offer accounts receivable programs for your consideration.

As a provider of health care, you may offer to MEDICARD holders the opportunity to charge visits to your office, the hospital emergency room and outpatient clinics, prescriptions, eyeglasses and contact lenses, laboratory tests, wheelchairs, crutches and braces, hearing aids, physical therapy, convalescent and special health care -- anything and everything for good health.

MEDICARD was created to provide consumers with a line of credit for medical and health care expenses at a time when these costs are skyrocketing. We provide a substantial line of credit so that people do not have to dig into their savings or borrow to the limit of their bank credit cards.

Our research has shown there is a great need for these services. We stand ready to offer you, and the community, financial good health.

Here's to good health, for everyone, with MEDICARD.

Sincerely,

Harold A. Dye, President

MEDICARD INCORPORATED
31 Executive Park Drive / P.O. Box 95329 / Atlanta, Georgia 30347 / (404) 325-2009

Incidental Intelligence . . .

Of Special Interest . . . Congressman Writes MAG Member Re PSRO

The following letter was written to MAG's former President, Milton I. Johnson, M.D., by Congressman Philip M. Crane, who serves on the Ways and Means Committee in the U.S. House of Representatives.

Dear Dr. Johnson:

In 1972, without so much as a hearing in the House of Representatives, Professional Standards Review Organizations (PSROs) were created by law. Ironically, this is one program that could have used plenty of debate. Maybe some of its flaws could have been discovered before it went into effect.

Last week I reopened the PSRO debate by introducing an amendment to eliminate this costly and ineffective federal program. Recent studies by the Congressional Budget Office and the General Accounting Office backed up my contention that PSROs are counterproductive. The CBO report concluded that PSROs were spending $100 million in administration expenses for every $70 million they saved in Medicare costs. The GAO audit found that savings reported by nine PSROs were unsubstantiated.

This faulty federal program also tampers with a physician's discretion to prescribe individualized treatment. PSRO norms and guidelines, which must be approved by the federal government, amount to cookbook medicine. Codified standards for medical treatment not only retard innovation and improvements in health care, they also interfere with the physician's discretion to handle each case uniquely and personally. In short, the quality of care is inhibited, not improved, by federal regulators.

Finally, I am concerned that PSRO review violates the deeply confidential relationship between doctor and patient. Medical records cannot be openly scrutinized without endangering many fundamental personal rights.

My amendment to eliminate the program and return to the far more successful pre-1972 concept of utilization review extracted from the Health Subcommittee a commitment for extensive hearings on PSROs. After seven years the House will finally hold hearings on a program that should have been examined before it ever began to waste money, jeopardize health care quality, and abridge privacy. You may want to inform Chairman Charles Rangel, Health Subcommittee, A412 House Office Building Annex 1, Washington, D.C. 20515, of your views on this topic.

Cordially,
Philip H. Crane
U.S. Congressman

Cobb County Annual Symposium — "You Are What You Think"

The 15th Annual Cobb County Symposium has been scheduled for April 17-18, 1980. Sponsored by the Cobb County Medical Society and the Cobb County Bar Association, the Cobb County Ministerial Association, and Kennesaw College, the Symposium will have as its main theme, "Thinking and Being: You Are What You Think."

Herbert Benson, M.D., Professor of Medicine at Harvard Medical School in Boston will speak on Thursday night, April 17, at Kennesaw College. He has written several books including "The Relaxation Response," and "The Body and The Mind." Bishop Arthur Vogel, Episcopal Bishop of the State of Missouri will speak on "Body Theology." Lewis Thomas, M.D., President of the Memorial Sloan-Kettering Cancer Center in New York City and author of "The Lives of a Cell" and "The Medusa and the Snail," has been invited to speak at the closing dinner.

For further information, write or call Symposium '80, Office of Development, Kennesaw College, Marietta, GA 30061, (404) 422-8770.

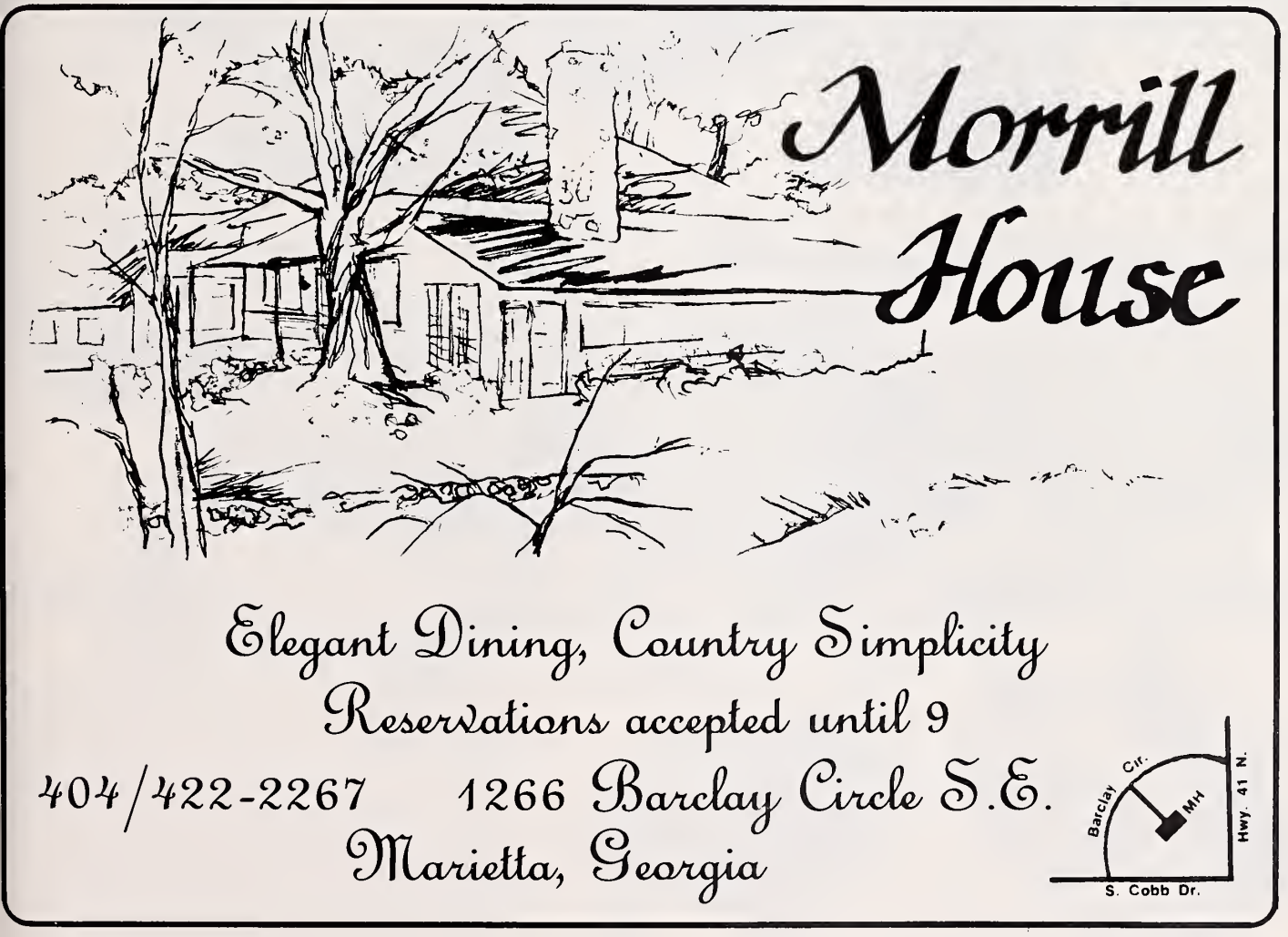
State Laboratory to Charge Fees for Service

Act 498 of the 1979 Georgia State Legislature authorized the state public health laboratory to charge fees for the services it provides. Proposed rules and regulations were formulated, and a public hearing was held on Dec. 5, 1979. After all the input from the public hearing is evaluated, the Board of Human Resources will adopt the rules in a subsequent meeting. Plans call for the fee system to be in place by spring 1980.

Current plans are to develop a prepaid stamp system in which the physician using the state laboratory services will purchase stamps in denominations of $2.00, $4.00, or $6.00 and affix these stamps to the laboratory request form that is sent in with the specimen to be examined. The following facts should be noted and will be built into the administrative procedure for collecting fees:

1. The law provides that the charges for laboratory services are not to exceed the actual cost of performing the tests.
2. The law also provides that no one will be denied service because of inability to pay.
3. Services provided by the state laboratory are not currently reimbursable by Medicaid so the fee will be waived in those cases where the physician provides the Medicaid account number of the patient.
4. The fee will be waived in certain instances when a physician certifies that his patient is unable to pay and that he does not intend to charge for the laboratory services.
5. Clients of local health departments will be exempt from the fee.
6. Certain federally funded projects, such as the gonorrhea culture program, will be exempt from the fees.
7. Services of immediate concern to public health, such as examinations for rabies, will be exempt from the fee.

As more information becomes available it will be provided directly to the persons using the public health laboratory.



The Complete Communication Company.

OFFICE COMMUNICATIONS INCORPORATED*

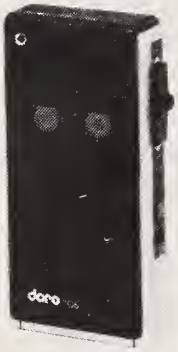
The Portables



NORELCO NT-1



NORELCO 185

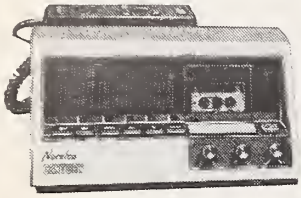


DORO 706



SA 150

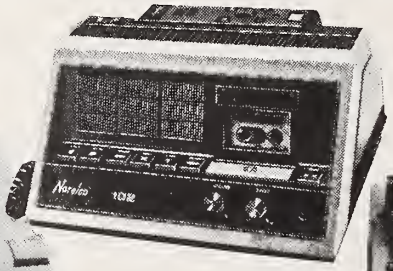
Desk Top Dictation/Transcription Systems



NORELCO CENTURY



DORO 707



DORO 705

NORELCO 102



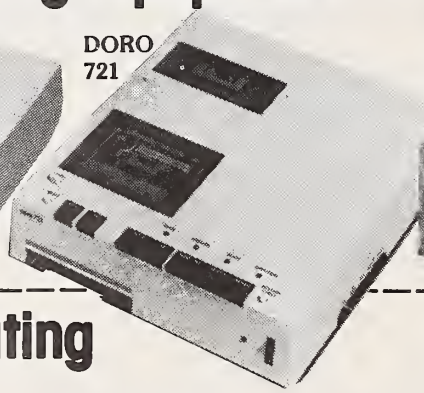
NORELCO 186

Phone Answering Equipment

SANYO 139



DORO 721



DORO 320



SANYO 9908



Telephone Dictating

NORELCO 260



DORO 732



*One Stop Communications Sales and Service...

OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service departments throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED

6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

WE BUILD MEDICAL OFFICES



Architectural
Engineering
Construction
Financing

One Guaranteed Price — No Cost Overuns

We can put together, for you, the Complete Program. DESIGN - DEVELOPMENT - SITE SELECTION - CONSTRUCTION. All work done by professionals under the supervision of State Registered Architects Engineers and Bonded Contractors all for one guaranteed price. Quality construction, low maintenance and operating costs are built into every building.

For More Information and Preliminary Estimates, Call or Write:

Robert G. Brownlow, President

MEDICAL BUILDINGS AND EQUIPMENT COMPANY, INC.

4399 Atlanta Highway • P. O. Box 305 • Loganville, Georgia 30249 • 404/466-2277

WELCOME

The

Medical Arts

Motel

5000 WATERS AVENUE
SAVANNAH, GEORGIA 31404

Savannah's Convenient Motel

"The Best for Less"

For Reservations

CALL 912-354-9710

Located near Memorial Medical Center and Medical Arts Shopping Center

Mrs. A. M. White
General Manager

Keogh— to prepare for the years ahead.

Keogh at Fulton Federal is a retirement plan for the self-employed. It allows you to contribute 15% of your earned income, up to $7500 per year, and defer taxes on your deposits, until you retire.

If you already have a Keogh Account, please note that contributions can be made as late as the tax filing deadline, including extensions.

To find out more, call Fulton Federal's Retirement Plan Counselors at (404) 586-7031. Keogh— it's the way to prepare for the years ahead, starting today.

EQUAL HOUSING LENDER

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 Atlanta, Georgia 30301 404-586-7283

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®



8-3305 (Y371A)



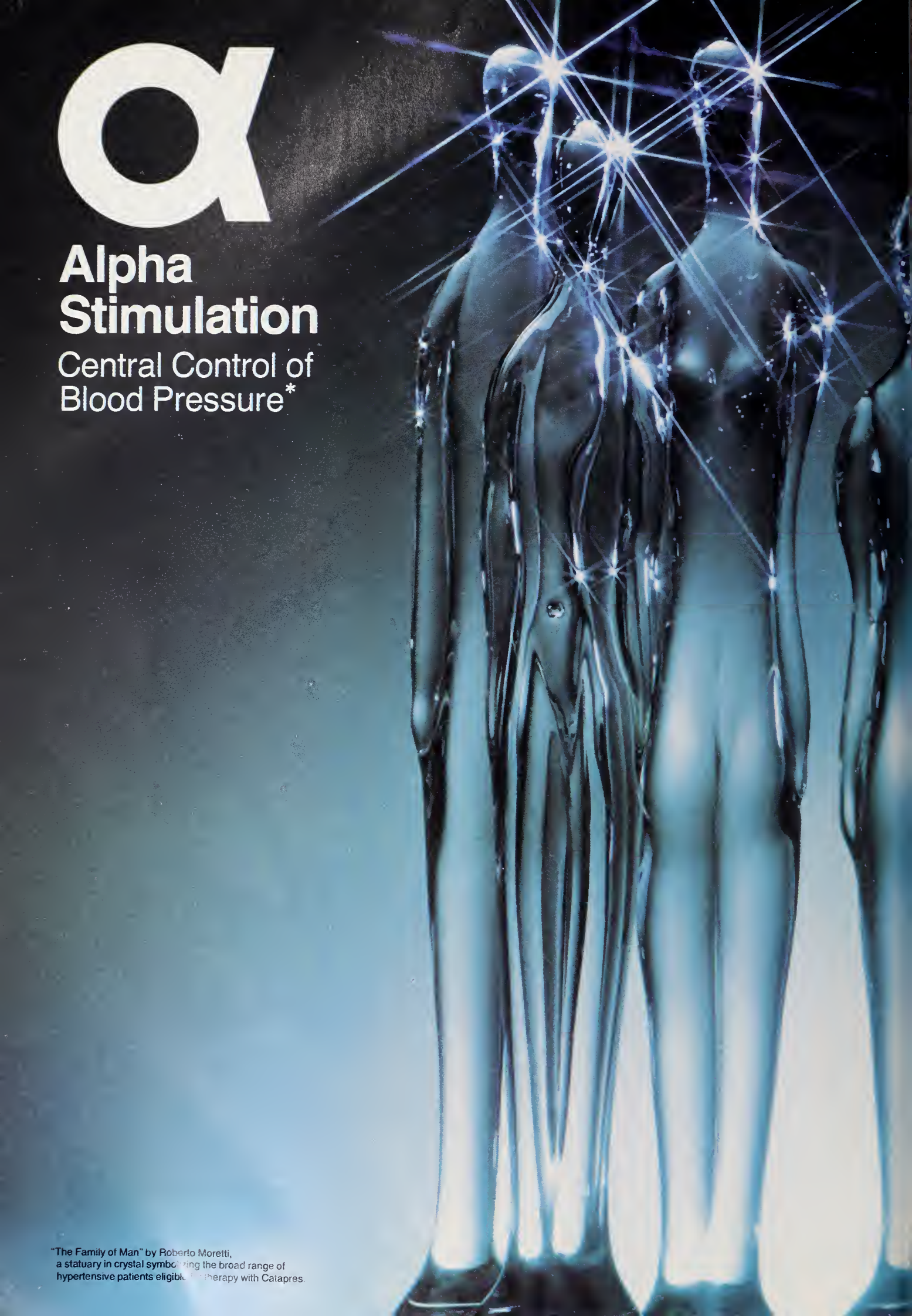
Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbo[illegible]zing the broad range of
hypertensive patients eligibl[illegible]herapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

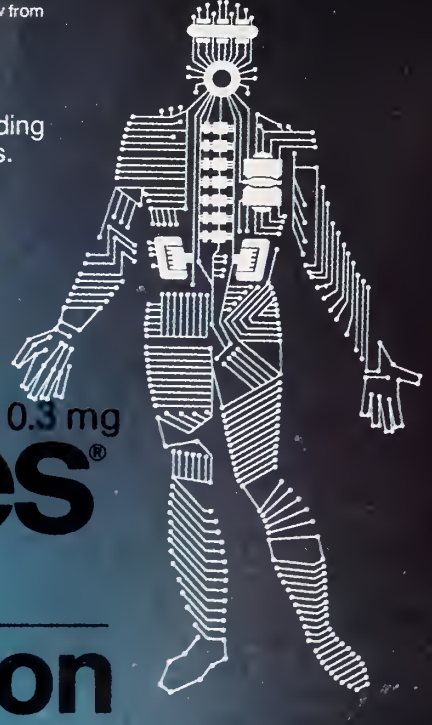
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets



Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension



The Alpha Advantage:

It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness a sedation. Constipation, dizziness, headache, and fatigue have been reporte Generally these effects tend to diminish with continued therapy. The followi reactions have been associated with the drug, some of them rarely. (In son instances an exact causal relationship has not been established.) These includ Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities liver function tests, one report of possible drug-induced hepatitis without icter and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chl thalidone and papaverine hydrochloride. Weight gain, transient elevation of blo glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud phenomenon; vivid dreams or nightmares, insomnia, other behavioral change nervousness, restlessness, anxiety and mental depression. Also rash, a gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associate with a rash, impotence, urinary retention, increased sensitivity to alcohol, drynes itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomasti weakly positive Coombs' test, asymptomatic electrocardiographic abnormaliti manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or a sent reflexes and vomiting followed the accidental ingestion of Catapres (clonidi hydrochloride) by several children from 19 months to 5 years of age. Gastr lavage and administration of an analeptic and vasopressor led to complete r covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minu intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) ove dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 m (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Als available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

BOEHRINGER INGELHEIM

Boehringer Ingelheim

Boehringer Ingelheim Ltd
Ridgefield, CT 06877

10 very selfish reasons for having a foreign student live with you for one year.

At first thought, adopting a foreign high school student for one year seems like a very generous thing to do.

It is. You give the student a chance to learn and grow in your community. The student makes new friends and becomes better acquainted with the world and its people.

On the other hand, hosting a foreign student can be a big benefit to you. Just look at all the things you can get from the deal.

1. A unique experience your entire family can share.
2. A way to increase communications with your own children.
3. A learning resource for yourself and your children.
4. A way of sharing your love with a young person.
5. A chance for personal growth.
6. An opportunity to make new friends around the world and in your town.
7. A chance to form a lasting relationship with a family abroad.
8. An exploration at home of rich cultural differences abroad.
9. A chance to know a young person from abroad. And that people around the world are basically the same.
10. An opportunity to see your family and community through the eyes of someone else.

Become a host family to an AFS student for one year. The student benefits, the community benefits and most of all, you and your family benefit.

Now that you know what you're getting, here's how you can get it.

For more information write to: AFS International/Intercultural Programs, 313 E. 43rd Street, N.Y., N.Y. 10017. Or call toll free (800) 327-2777. In Florida (800) 432-2766.

AFS International Exchanges for high school students.

We provide the students. You provide the love.





This heroic sculpture by Rodin, "The Shade," was given to the City of Atlanta by France after the 1963 airplane crash in Orly, France, in which many prominent Atlanta art patrons and supporters died. Displayed simply and elegantly at the High Museum, this compassionate, introspective work paradoxically suggests not only movement, with an outstretched arm toward an unseen goal, but also stillness, with the head reclined as in a deep slumber. Let us as physicians define *our* goals specifically in preparation for the Annual Meeting in April, the while keeping an informed vigil on current affairs. Then will we be able to more effectively impact on medical politics in our state and nation.

JOURNAL
of the medical association of
georgia

The 126th Annual Business Meeting of The Medical Association of Georgia

On April 24, 1980, the Medical Association of Georgia's (MAG's) House of Delegates will convene at 8:00 p.m. in the Grand Salon East of the Atlanta Hilton. The House of Delegates will be preceded by a General Session of Association Members at 7:00 p.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the scientific portion of the meeting was separated from the business portion and is held in November of each year.

Hotel Reservations

The Atlanta Hilton is the headquarters for this meeting and will be the only hotel we will be using. All MAG delegates, alternate delegates, and association officers will be receiving hotel reservation cards from MAG Headquarters. All others must make reservations directly with the hotel. The address is: Atlanta Hilton, 255 Courtland St., NE, Atlanta, GA 30303.

Registration

Registration facilities will be maintained in the Prefunction West, outside the Grand Salon East, for delegates, alternate delegates, directors, and all members. Registration hours will be as follows:

Thursday, April 24 3 p.m.-7 p.m.
Friday, April 25 7:30 a.m.-12:00 noon
Saturday, April 26 ... 8:30 a.m.-5:00 p.m.
(After 12 noon, please come to MAG Headquarters office.)
Sunday, April 27 ... 7:00 a.m.-12:00 noon

Headquarters Office

The MAG staff will maintain an office on the 4th floor of the Hilton.

Message Center

The Auxiliary to the MAG will maintain a message desk in the Prefunction West of the hotel for the convenience of the membership. The messages will be posted on a bulletin board at the message desk in Prefunction West.

General Sessions

The opening General Session will be called to order by MAG's president, Earnest C. Atkins, M.D., on Thursday, April 24, at 7:00 p.m. in the Grand Salon East. Featured during this opening ceremony will be the presentation of the report of the President of the Auxiliary to MAG.

There will be no General Session on Saturday.

The Second General Session will be held following adjournment of the House of Delegates on Sunday, April 27. At this time, the newly-elected officers will be installed.

House of Delegates

The first session of the House of Delegates will convene on Thursday, April 24, at 8:00 p.m. in the Grand Salon East of the Atlanta Hilton. Nominations for MAG officers will be made, and reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference committees will be appointed and all resolutions and reports will be referred by the speaker to the appropriate reference committees.

The second session of the House of Delegates will convene at 10:00 a.m. on Saturday, April 26, in the Grand Salon East. Reference committees will report to the House at this time.

The third and final session of the House of Delegates will convene at 9:00 a.m. on Sunday, April 27, at which time the results of the election of officers

will be announced and the remaining Reference Committee reports will be presented.

Reference Committees

According to the Bylaws of the Association, all resolutions and reports which contain recommendations must be referred to reference committees for open hearings. All members are invited and encouraged to appear before the reference committees to express their views. The reference committees will open their hearings on Friday, April 25, at 9:00 a.m.

Election of Officers

Nominations for the officers of the Association will be made during the first session of the House of Delegates on Thursday, April 24. The election will take place before the House of Delegates on Sunday, April 27. Delegates will be certified by members of the Credentials Committee and receive their ballots at that time. Voting will be done in appropriate voting booths. After the polls close at 9:00 a.m., the Tellers Committee will count the ballots, and the results will be announced at the General Session following the adjournment of the House of Delegates. If it is necessary to have a run-off election, it will be held during the House meeting.

President's Reception

The MAG will honor its president at a reception to be held at 7:00 p.m., Saturday, April 26.

Alumni Events

Receptions and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

AMA President Hoyt D. Gardner, M.D. To Be MAG's Guest Speaker



HOYT D. GARDNER, M.D., 1979-80 President of the American Medical Association (AMA), will be the guest speaker at the House of Delegates Meeting on Saturday morning, April 16.

Dr. Gardner is in the private practice of general surgery in Louisville, Kentucky, where he has been active for many years in the Kentucky Medical Association.

Prior to his election at the 1978 Annual Convention in Dallas, he served as a member of the AMA Board of Trustees from 1974 until 1978, when he was elected President-Elect of the AMA.

Long active in the medical society activities, Dr. Gardner is the Past President of the Kentucky Medical Association, Past President of the Jefferson Medical Society in Louisville, and was Chairman of the Board of Directors of the American Medical Political Action Committee from 1971 until 1972. He also served as that Committee's Secretary/Treasurer from 1967 to 1968, and is the former Chairman of the Kentucky Medical Political Committee. He is a Fellow of the American College of Surgeons and is former Chairman of the Louisville Jefferson County Board of Health, and a member of the Kentucky Republican State Central Committee.

In October 1978, Dr. Gardner was honored by the University of Louisville, where he was presented with the Outstanding Alumni Award. The following month he received the Outstanding Citizens Award from the Louisville Jaycees.

Dr. Gardner, whose organized medicine activities date back to his medical school days, is a member of honorary fraternities Omicron, Delta Kappa, and Alpha Omega Alpha, and a member of the Delta Tau Delta social fraternity and Alpha Kappa Kappa medical fraternity.

Dr. Gardner is married, has three children, and his principal hobby is collecting first editions of Nineteenth Century American authors. He has amassed a sizeable collection, including all of Oliver Wendell Holmes' and Mark Twain's works.

His speech this year, at the House of Delegates meeting promises to be enlightening and inspiring, and is certain to be a highlight of this year's 126th MAG Annual Session.

Officers of the Association

1979-1980



ATKINS



HAMMETT



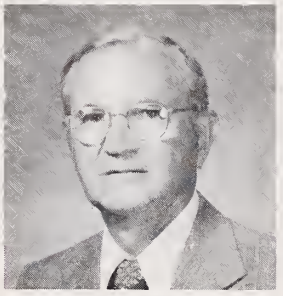
BURGSTINER



STUBBS



GRIFFIN



CLARK



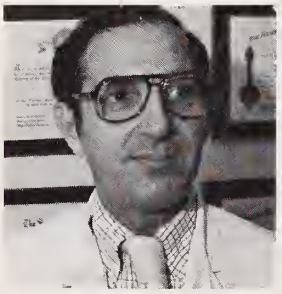
LOGAN



SULLIVAN



BUCHANAN



MENENDEZ



WOODY

Office Held		Term Ending
PRESIDENT	Earnest C. Atkins, Atlanta	1980
PRESIDENT-ELECT	H. Hilt Hammett Jr., LaGrange	1980
IMMEDIATE PAST PRESIDENT	Carson B. Burgstiner, Savannah	1980
PAST PRESIDENT	Milton I. Johnson, Macon	1981
PAST PRESIDENT	Fleming L. Jolley, Atlanta	1980
CHAIRMAN OF THE BOARD OF DIRECTORS	Joe C. Stubbs, Valdosta	1980
FIRST VICE PRESIDENT	Richard A. Griffin III, Cartersville	1980
SECOND VICE PRESIDENT	S. William Clark Jr., Waycross	1980
VICE CHAIRMAN OF THE BOARD OF DIRECTORS	Jack A. Raines, Columbus	1980
SECRETARY	William D. Logan Jr., Atlanta	1981
TREASURER	James H. Sullivan, Columbus	1981
SPEAKER OF THE HOUSE	L. C. Buchanan, Decatur	1980
VICE SPEAKER OF THE HOUSE	Jack Menendez, Macon	1980
EDITOR, *JMAG*	Edgar Woody Jr., Atlanta	1980



Tennyson wrote, "The old order changeth, yielding place to the new." So does the Atlanta skyline which is often a source of frustration to photographers. Each picture taken quickly becomes obsolete as more and more of the gleaming skyscrapers appear on the forested horizon.

Component County Society Representation to the 1980 House of Delegates

(1979 CMS Member Count for 1980 Delegates to Annual Session—Tentative)

County Medical Society	Number of Delegates
Altamaha	1
Baldwin	2
Barrow	1
Bartow	1
Ben Hill-Irwin	1
Bibb	9
Blue Ridge	1
Ogeechee River	2
Burke	1
Carroll-Haralson	2
Georgia Medical Society	10
Elbert	1
Chattahoochee	2
Cherokee-Pickens	1
Crawford W. Long	4
Clayton-Fayette	3
Cobb	11
Coffee	1
Colquitt	1
Coweta	1
Decatur-Seminole	1
DeKalb	13
Dougherty	5
Camden-Charlton	1
Emanuel	1
Flint	1
Floyd-Polk-Chattooga	5
Franklin-Hart	1
Medical Association of Atlanta	50
Glynn	3
Gordon	1
Douglas	1
Habersham	1
Hall	5
Peach Belt	2

County Medical Society	Number of Delegates
Jackson-Banks	1
Jefferson	1
Laurens	2
McDuffie	1
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	10
Newton-Rockdale	1
Oconee Valley	1
Ocmulgee	1
Randolph-Stewart-Terrell	1
Richmond	14
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	1
Sumter	1
St. John's Parish	1
Thomas Area	3
Tift	2
Troup	3
Upson	2
Walker-Catoosa-Dade	2
Walton	1
Ware	3
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1



These men were leaders in their fields as well. This Confederate Memorial to Stonewall Jackson, Jefferson Davis, and Robert E. Lee is cut into the face of Stone Mountain, the world's largest mass of exposed granite.

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies, and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters no later than March 15. If no nominations and supporting data are received, no award will be made. No nominations for this award will be accepted from the floor. If given, this award will be presented on Thursday, April 24. By custom, this award usually has gone to a Georgia physician; however, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at MAG Headquarters no later than March 15. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Thursday, April 24.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at MAG Headquarters no later than March 15. The recipient of this award will be selected by a three-man secret committee which will determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Thursday, April 24.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The president of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Thursday, April 24. Deadline for receiving nominations for this award was January 15, 1980.

Welcome to Atlanta!

To the Members of the Medical Association of Georgia:

On behalf of the Medical Association of Atlanta, I would like to extend you an invitation to attend the meeting of the House of Delegates, April 24-27, 1980, at the Atlanta Hilton.

Frank L. Wilson Jr., M.D.
President, Medical Association of Atlanta

DIRECTORS AND ALTERNATE DIRECTORS

District	Director	Alternate Director	Term Ending
1	Leon E. Curry, Metter	Charles R. Richardson, Statesboro	1982
2	J. Dan Bateman, Albany	Sammie Dixon, Tifton	1982
3	V. W. McEver Jr., Warner Robins	L. Kenneth Raynor, Warner Robins	1982
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1980
7	Richard A. Griffin III, Cartersville	D. R. Mahan, Dalton	1980
8	Joe C. Stubbs, Valdosta	Michel A. Glucksman, Brunswick	1980
9	Rupert H. Bramblett, Cumming	L. Austin Flint, Canton	1981
10	M. A. Hubert, Athens	Wm. M. Headley, Milledgeville	1981
Bibb County Medical Society			
	Beverly B. Sanders, Macon	Rodney M. Browne, Macon	1981
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1981
DeKalb Medical Society			
	John P. Heard, Decatur	Roy W. Vandiver, Decatur	1981
Floyd-Polk-Chattooga Medical Society			
	John I. Dickinson, Rome	Robert A. Farrell, Rome	1981
Medical Association of Atlanta			
	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1980
	T. J. Anderson Jr., Atlanta	William C. Collins, Atlanta	1980
	J. Harold Harrison, Atlanta	William C. Waters III, Atlanta	1982
Georgia Medical Society			
	Joe L. Nettles, Savannah	Clyde L. Olson, Savannah	1982
Muscogee County Medical Society			
	Jack A. Raines, Columbus	E. M. Molnar, Columbus	1980
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Luther M. Thomas, Augusta	1981

AMA DELEGATES AND ALTERNATE DELEGATES, JANUARY 1, 1980

Delegates	Term Ending	Alternate Delegates	Term Ending
C. Emory Bohler, Brooklet	12-31-81	Carson B. Burgstiner, Savannah	12-31-81
F. W. Dowda, Atlanta	12-31-81	Charles D. Hollis, Albany	12-31-81
Harrison L. Rogers Jr., Atlanta	12-31-80	H. Hilt Hammett Jr., La Grange	12-31-80
J. Dan Bateman, Albany	12-31-80	W. W. Moore, Atlanta	12-31-80



The Peachtree Center Complex in downtown Atlanta is renowned for its unique, modern architecture. The center includes office buildings, elegant shops, restaurants, and two of architect John Portman's most beautiful and exciting hotels.

Offic

(All functions of the House of De

THURSDAY, APRIL 24

4:00-7:00 p.m.

Registration of Delegates and Other Session Attendees
Location: Prefunction West

7:00 p.m.

General Session
Location: Grand Salon East

Presiding: Earnest C. Atkins, M.D., President

Opening Ceremonies

Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. Michel A. Glucksman, of Brunswick

Presentation of Association Awards
- Family Physician of the Year
- Hardman Cup
- Civic Endeavor Award
- Distinguished Service Award

Announcements

Recess

8:00-10:00 p.m.

House of Delegates, First Session
Location: Grand Salon East

Presiding: L. C. Buchanan, M.D., Speaker, and Jack F. Menendez, M.D., Vice Speaker

Presentation, Correction, and Adoption of the Minutes of the 1979 House of Delegates

Appointment of Convention Committees

Nominations for Association Officers and AMA Delegates

Reports of Officers and Committees

Introduction of New Business

Announcements

Recess

FRIDAY, APRIL 25

7:30 a.m.

Registration
Location: Prefunction West

9:00 a.m.

Reference Committee Hearings
Cabinet Room, Council Room, Club Room, State Room, Room 422, Room 436, Room 438

ogram

held in the Atlanta Hilton)

SATURDAY, APRIL 26

8:30 a.m.	**Registration** *Location: Prefunction West*
10:00 a.m.	**House of Delegates, Second Session** *Location: Grand Salon East*
	Address by: Hoyt D. Gardner, M.D., President, American Medical Association (All MAG members, Auxiliary members, and guests are cordially invited)
7:00 p.m.	**President's Reception**

SUNDAY, APRIL 27

7:00 a.m.	**Registration** *Location: Prefunction West*
7:00 a.m.-9:00 a.m.	**Polls Open for Election of Association Officers and AMA Delegates** *Location: Prefunction West*
9:00 a.m.	**House of Delegates, Third and Final Session** *Location: Grand Salon East*
	Presiding: L. C. Buchanan, M.D., Speaker, and Jack F. Menendez, M.D., Vice Speaker
	Invocation
	Reports of Reference Committees
	Announcements
	Announcements of Election Results
	Adjournment of House of Delegates
12:00 Noon	**General Session, Final** *Location: Grand Salon East*
	Presiding: Earnest C. Atkins, M.D., President
	Installation of Officers
	Adjournment of 126th Annual Session

1980 Auxiliary Annual Convention Schedule

THURSDAY, APRIL 24

8:30 a.m.-5:00 p.m.
Registration and Information
Location:
Prefunction North

8:00 a.m.-5:00 p.m.
Hospitality and Exhibits
Location:
Fulton, Cobb, Clayton Rooms

1:30 p.m.-5:00 p.m.
Auxiliary First General Session
Location:
Fulton, Cobb, Clayton Rooms

8:00 p.m.-10:00 p.m.
Auxiliary Reception
Location:
Crystal Ballroom, Parlors F and G

FRIDAY, APRIL 25

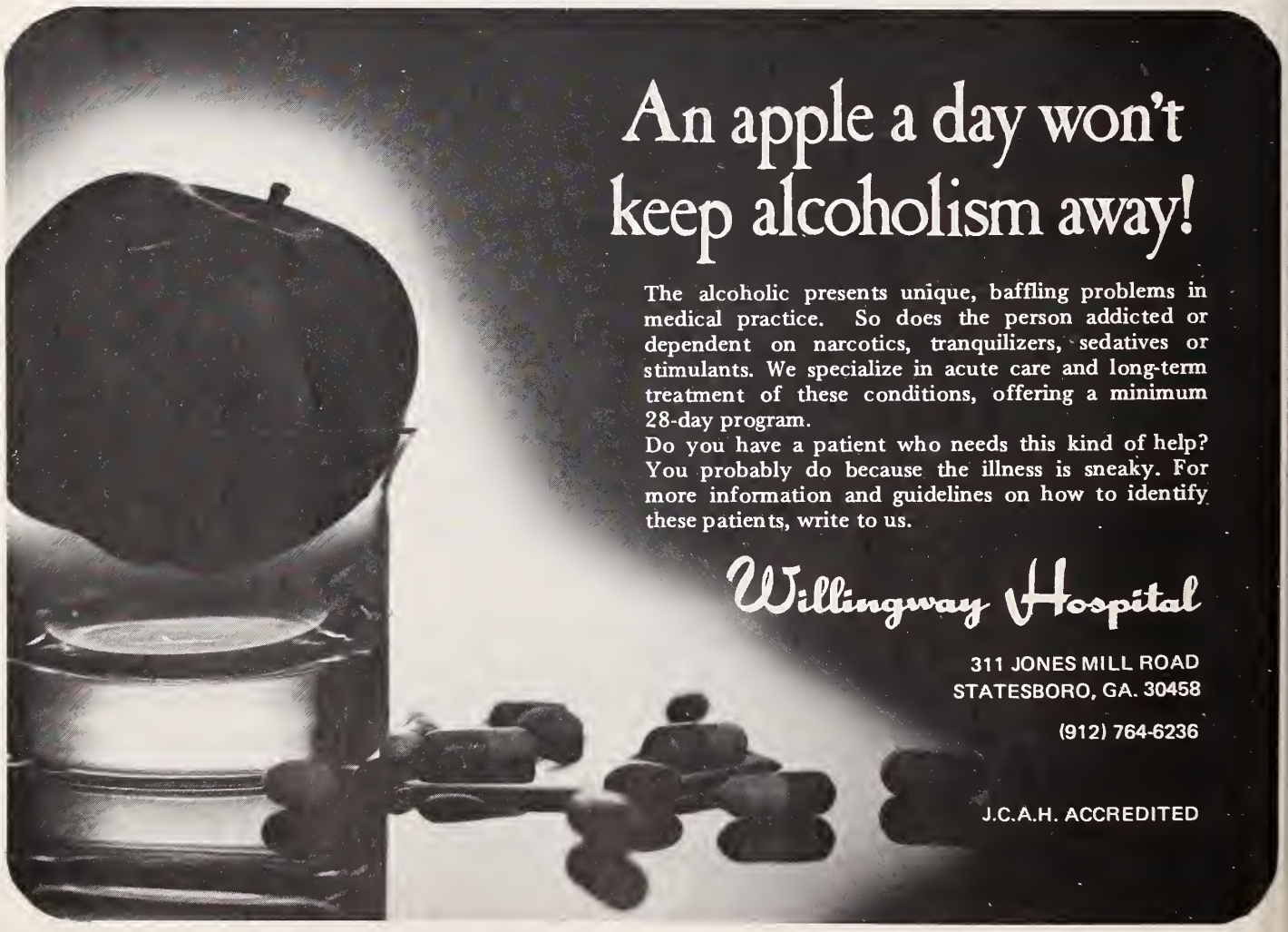
8:30 a.m.-5:00 p.m.
Registration and Information
Location:
Prefunction North

8:30 a.m.-5:00 p.m.
Hospitality and Exhibits
Location:
Fulton, Cobb, Clayton Rooms

9:00 a.m.-11:30 a.m.
Second General Session
Location:
Fulton, Cobb, Clayton Rooms

1:00 p.m.-2:00 p.m.
Luncheon
Location:
Crystal Ballroom, Parlors E and F, Lower Lobby

2:30 p.m.
Post Convention Board Meeting
Location:
Fulton, Cobb, Clayton Rooms



The 55th Annual Auxiliary Convention



Welcome to Atlanta!

WE ARE DELIGHTED to welcome the Auxiliary to the Medical Association of Georgia to Atlanta, especially because our city is so refreshingly beautiful in the spring. There is nothing we enjoy more than showing visitors the beautiful yards and gardens in all their blooming glory. Don't leave here without seeing at least one outstanding residential area.

Of course, there is always wonderful shopping downtown as well as in the numerous malls, but why not try something a bit different? Try a browsing excursion to one of our many art galleries, a visit to the Department of Archives, the Capitol, Emory University, or Fernbank Science Center, or take a rambling walk through the Omni or Colony Square. Would you like to indulge and pamper your well-deserved self? Then visit one of the health spas or total beauty salons for "the works"! A visit to the Decorators Show House would be surprisingly entertaining and educational. There truly is something for everyone, from the sublime to — yes, even the ridiculous! So, enjoy your visit. Look for a list of places to go and things to do at our hospitality rooms in the Atlanta Hilton.

In addition to all of the sights and sounds of Atlanta to entertain you, don't forget to attend the Auxiliary meetings at the Hilton, beginning April 24 and lasting until April 27. See you there!

Barbara M. Haltiwanger, (Mrs. Earl)
President, Auxiliary to the
Medical Association of Atlanta



President's Greeting

ATLANTA WILL BE THE SITE, once again, of the Annual Meeting of the Auxiliary to the Medical Association of Georgia. All members are invited and encouraged to attend.

The Hilton Hotel will be headquarters this year for both the Auxiliary and the Medical Association conventions, so please make your reservations early.

We are both pleased and honored to have Mrs. Ben Johnson Jr., President of the American Medical Association Auxiliary, as our special guest.

The Medical Association of Atlanta Auxiliary is the host auxiliary for the convention. They will be assisted by two co-hosts, Cobb and Crawford W. Long Auxiliaries.

Please come join us in fun-filled Atlanta on April 24, 25, and 26.

Mrs. M. A. Glucksman
President, Auxiliary to the Medical
Association of Georgia

Special things to see and do in Atlanta are highlighted here.

The Allure of Atlanta

SUSAN J. DILLON, *Atlanta**

ATLANTA OFFERS an exciting variety of things to see, taste, smell, buy, ride — in short, a multiplicity of experiences to participate in and enjoy. You can take a walking tour of the downtown area or a driving tour of some of the most beautiful residential areas in the country, colorfully decorated with spring flora. You can even get in a little star trekking in the country's third largest planetarium. World-famous designer clothes and accessories are available in large stores and small boutiques. And when you finally take time to dine, you'll find plenty on the plate to please your palate, with good eating from French, Italian, Japanese, Scandinavian, Persian, or Greek to grits. In addition to those places and sights and sounds already featured in this issue, here are some other things to do to add to your enjoyment of Atlanta.

Underground Atlanta

During Atlanta's reconstruction period after the Civil War, city planners built viaducts and bridges which raised the city to its present level. Business moved "upstairs." Underground was eventually restored as a place of interest and entertainment, where today you'll find a wax museum, many shops, boutiques, discotheques, and fine restaurants.

Theater

More than 12 local theater groups, including Alliance Theater, The Academy Theater, and Atlanta's Children's Theater, offer productions covering a wide spectrum of comedy and drama. Theater of the Stars imports Hollywood and Broadway actors for winter plays and summer musicals. Several dinner theaters compliment their menus with live productions.



Atlanta's Memorial Arts Center

Art Exhibits

The Memorial Arts Center's High Museum hosts an outstanding permanent collection, special exhibitions, and a junior gallery for children. Almost 50 other galleries operate in Atlanta, with shows ranging from contemporary graphics and photography to the fine art of the Renaissance. The Arts Festival of Atlanta, held every spring in Piedmont Park, features competitive exhibitions, dance, drama, and musical performances.

The Fox Theater

Located at 660 Peachtree St., the Fox is not your run-of-the-mill movie theater but a complex of different facilities, including the 7,000-square foot Egyptian Ballroom, Grand Salon, executive offices, and the Grand Auditorium. The auditorium was envisioned and designed as an open courtyard in a Moorish city, with twinkling stars and floating clouds in an azure sky. Counted in the National

* Mrs. Dillon is the managing editor of the *Journal*.



The contemporary symbol of Atlanta is the phoenix which, according to legend, rose from its own ashes with renewed strength and beauty. Rising out of the ashes left by General Sherman's fires, Atlanta has experienced phenomenal growth. In the 1960's alone, more than 100 new office buildings, with over 17 million square feet of space, were built in this city.

Register of Historic Places, the Fox is still used for the performances of a wide scope of entertainment, from Broadway musicals and rock concerts to religious revivals.

Tullie Smith House Restoration

This "plain plantation style" farmhouse, relocated to the Buckhead business district at 3099 Andrews Dr., NW, is an authentic and unique document regarding the lifestyle of the early settlers in inland Georgia. Originally built around 1840, it is one of the few surviving pre-Civil War houses in the Atlanta area. Outbuildings, such as the kitchen, barn, slave cabin, and double corn crib, use hand-hewn logs joined in a V-notch construction. There are guided tours which have recently been translated into French, German, Spanish, and Japanese as a gift to the community from the Junior League of Atlanta, Inc. A craftshop features traditional hand-made Georgia crafts.

The Swan House

Also located at 3099 Andrews Dr., NW, this was once the old Inman Estate and remains one of Atlanta's most spectacular homes. Built in 1929, its inspiration was gleaned from earlier European schools of architecture. Both of the Inmans were fond of birds — swans, in particular — and incorporated a swan motif into the architectural detail and the furnishings they collected in this country and in Europe. At least one swan is found in each room, such as the ones carved amidst rocks, reeds and water plants on a pair of 18th century console tables attributed to the London carver, Thomas Johnson. The lush lawn terraces, statuary, and pools (which are especially beautiful in the spring), the rich paneling, marble floors, moulded ceilings, and exquisite antique furnishings offer a glimpse of the elegant taste and opulent living that took place during the roaringly affluent 1920's in Atlanta. Experienced tour leaders guide visitors through the various period rooms. On the nearby grounds are the original servants' quarters. They have been converted into the popular Coach House, which contains a distinctive luncheon restaurant, art gallery, and gift shop.



Swan House

Wren's Nest

Here, in the home of Joel Chandler Harris and Uncle Remus, the beloved characters, Br'er Rabbit, Br'er Fox, and the many other "critters" were created. Today, the Wren's Nest, Uncle Remus' cabin, and the grounds, located at 1050 Gordon St., SW, have been preserved much as they were during Mr. Harris' lifetime.

Martin Luther King Jr. Memorial Center

Located at Jackson and Auburn Avenue, the tomb of Atlanta's native son, Civil Rights leader, and Nobel Peace Prize winner is next to the Ebenezer Baptist Church, which is so closely identified with his life, work, and death. The house where King was born is in the next block. Nearby also is the Martin Luther King Jr. Center for Social Change.

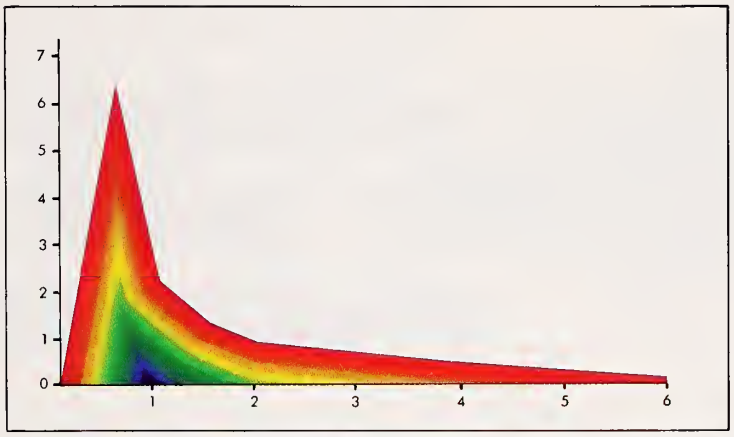
The Coca-Cola Company

Before the turn of the century druggist John Pemberton sold his first headache tonic at the soda fountain of Jacob's Pharmacy at Five Points. The accidental addition of carbonated water turned the beverage into an overnight sensation. Eventually, another pharmacist, Asa G. Candler, became sole owner of the innovative drink. In 1919, Coca-Cola was sold for $25,000,000, and since then, as virtually everyone knows, it has grown into one of the world's largest international companies. For the complete, refreshing story, stop by the visitor's center at the Coca-Cola Company, 310 North Ave.

Where Else to Look

Atlanta Magazine, Off Peachtree, Brown's Guide to Georgia, and *Southern Living* are just a few of the excellent guides to entertainment and recreational spots in Atlanta and environs. This article has suggested only a small part of the allure of Atlanta. Come for a visit and discover even more on your own.

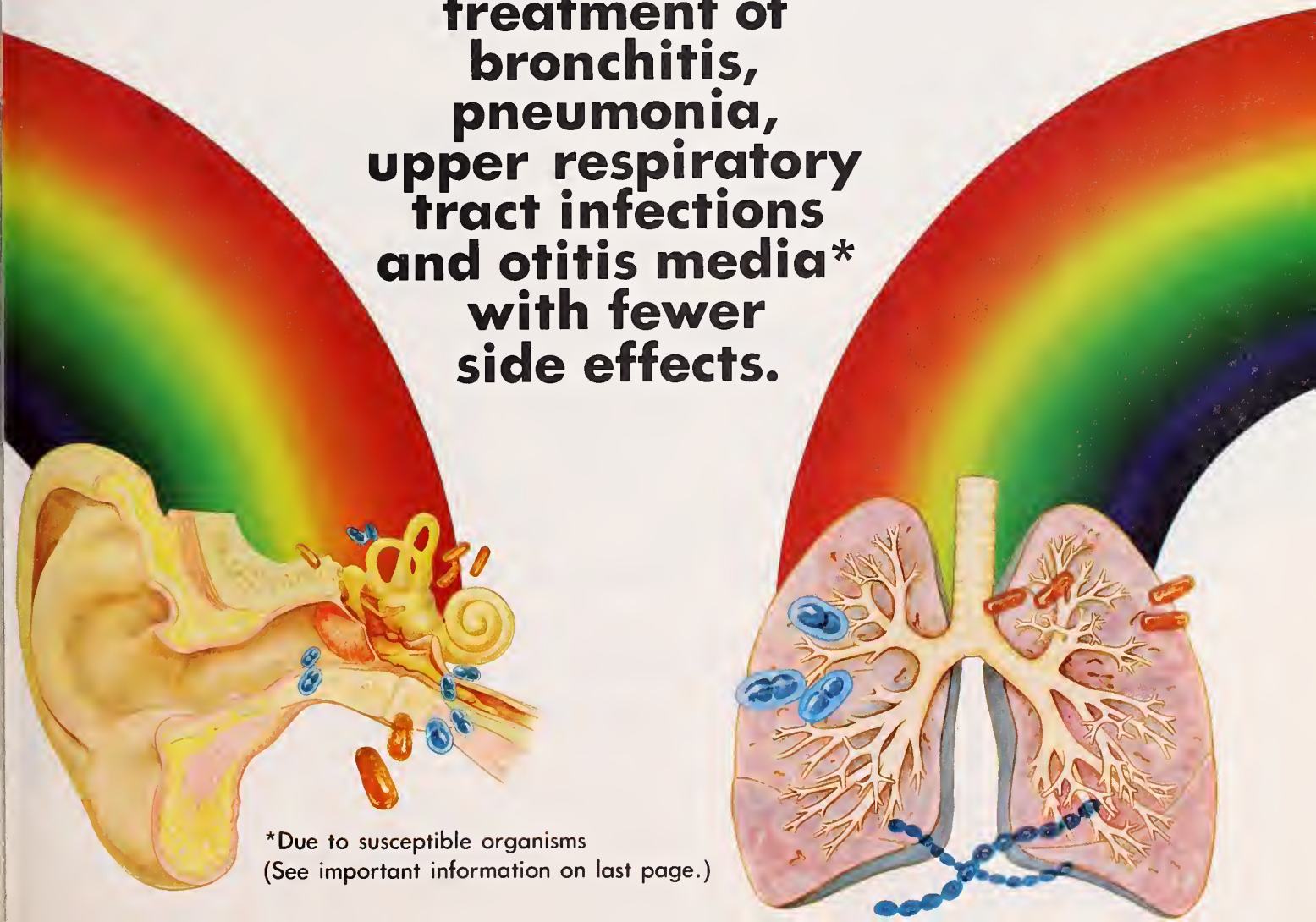
more than just spectrum



New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of bronchitis, pneumonia, upper respiratory tract infections and otitis media* with fewer side effects.



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN®
(cyclacillin) Tablets/ Suspension

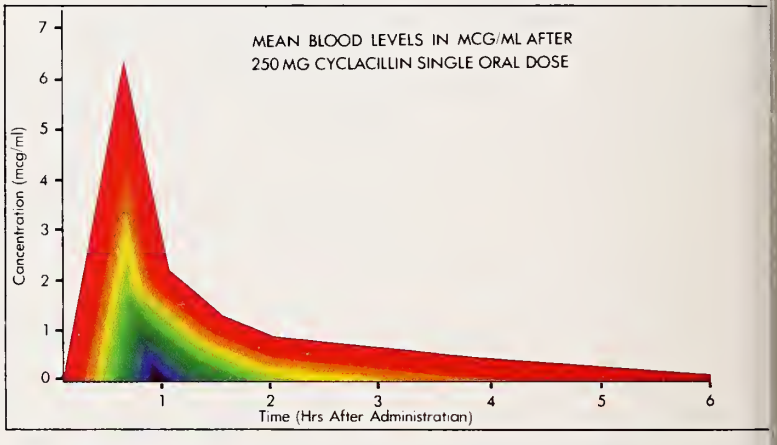
efficacy with fewer side
ampicillin confirmed in
studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin



High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100 / 95	73
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92 — Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	12
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100 / 86	44
	% Clinical Response % Bacterial Eradication	



more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

Copyright © 1979, Wyeth Laboratories. All rights reserved.

effects than double-blind patients*



Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant ($P < 0.001$)	

more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
S. pneumoniae	96 / 95	82
H. influenzae	88 / 85	96
	% Clinical Response / % Bacterial Eradication	

CYCLAPEN® (cyclacillin)
Effective for bronchitis, pneumonia, and upper respiratory tract infections†

- Excellent clinical results in bronchitis, pneumonia and upper respiratory tract infections
- Significantly lower incidence of diarrhea and skin rash

1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.

more than just spectrum CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Wyeth Laboratories
Philadelphia, Pa. 19101

(See important information on next page)

New from Wyeth Laboratories

CYCLAPEN®
(cyclacillin) Tablets/ Suspension



more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY. Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended.

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa 19101

Clinicopathological Conference

JOHN F. FISHER, M.D., and RAGHUNATHA RAO, M.D., *Augusta**

Case Report

A 47-YEAR-OLD black woman was referred to the Medical College of Georgia (MCG) in Augusta, Georgia, in a coma. She had received hemodialysis for the past 5 years, having last been dialyzed 2 days prior to admission in a community hospital. Immediately following this dialysis she complained of generalized weakness. Twenty-four hours later, fever (39.4°C) and chills developed. She consulted her private physician who prescribed several medications and sent her home. She returned to him later that day because of increasing fever (40.5°C). The patient was admitted and given carbenicillin 5 mg intravenously every 8 hours. She was transferred to MCG when she lapsed into a coma that night.

The patient was status 10 years post right mastectomy for carcinoma of the breast. She was also a known diabetic with hypertension and a history of previous myocardial infarction.

On physical examination, the patient was comatose and unresponsive to noxious stimuli (T 37°C, R 16-20 and irregular, P 92, BP 120/50). Several small macules were noted on the arms and thighs. The pupils were dilated and unreactive to light. A large left cataract precluded examination of the fundus. The right fundus was blurred. The neck was described as probably supple. Cardiovascular examination revealed a grade III/VI systolic ejection murmur at the left sternal border. A purulent vaginal discharge was noted on pelvic examination. Spontaneous movement of lower extremities, initially absent, began 2 hours after admission. Her reflexes were described as 1−2+ and symmetrical. Bilateral Babinski's signs were present. The oculocephalic reflex was intact. A "fast component nystagmus" was noted on cold caloric stimulation of the right external auditory canal. No response was appreciated on the left.

The urine was grossly bloody, and greater than 10^5 colonies/ml of *Klebsiella pneumoniae* and *Staphylococcus epidermidis* were isolated from urine cultures. The white blood cell count was 14,000 with 44% segmented neutrophiles, 41% band neutrophiles, 10% lymphocytes, 4% monocytes, and 1% eosinophiles. The following blood chemistries were recorded: total protein, 7.6 gm/dl; albumin 2.8 mg/dl; calcium 11 mg/dl; phosphorus 4.4 mg/dl; uric acid 8.8 mg/dl; creatinine 15.6 mg/dl; lactose dehydrogenase 290 mU/ml; aspartate aminotransferase (SGOT) 33 mU/ml; urea nitrogen 97 mg/dl; glucose 305 mg/dl; sodium 140 mEq/l; potassium 4.9 mEq/l; bicarbonate 18 mEq/l; chloride 95 mEq/l.

Chloramphenicol was begun, and the patient was dialyzed peritoneally. Neurologic consultants diagnosed a brain stem lesion versus a metabolic encephalopathy. The Infectious Diseases Service could not exclude a partially treated meningitis. In spite of therapy, the patient never regained consciousness, and on the eighth hospital day, she sustained a fatal cardiorespiratory arrest. An autopsy was performed.

Differential Diagnosis

In my opinion, the following are important historical facts in this patient. She was a 47-year-old black diabetic woman on chronic hemodialysis. She had a short history of fever, chills, and prostration, treated unsuccessfully with antibiotics. Coma developed rapidly. The patient had had carcinoma of the breast some 10 years prior to the present illness.

There were several important physical findings as I see them: She was comatose, with dilated, nonreactive pupils, bilateral Babinski signs, and abnor-

* Dr. Fisher is Assistant Professor of Medicine, Infectious Disease Division, at the Medical College of Georgia (MCG). Dr. Rao is Associate Professor and Director of Anatomic Pathology at MCG, Augusta, GA 30912. Direct reprint requests to Dr. Fisher, Infectious Diseases, Talmadge Memorial Hospital, 751 Lancaster, Augusta, GA 30909.

mal calorics. Her neck was supple. She had a heart murmur. Several macules were noted over her arms and thighs.

Important laboratory findings included: an elevated white blood cell count with a left shift, abnormal arterial gases, a blood glucose of 305 mg/dl, a diffusely abnormal electroencephalogram (EEG), an abnormal cerebrospinal fluid [CSF (protein elevated at 88 mg/dl, sugar 220, 13 RBC's, 19 WBC's of which several were polymorphonuclear leucocytes)], an abnormal electrocardiogram, a computed tomographic (CT) scan which showed that the left lateral ventricle was mildly dilated, an elevated lactic dehydrogenase (LDH), and bacteriuria.

How, then, do we interpret the physical findings in this patient? Coma indicated that either marked and diffuse cerebral disease was present, or that there was a localized lesion in the reticular activating system. The fact that her pupils were dilated and nonreactive implied a lesion in the Edinger-Westphal nucleus in the midbrain. Spontaneous movement of the lower extremities suggested that the pyramidal tracts were at least partially intact. When cold water was instilled into her right ear a "fast component nystagmus" was described. This description is difficult to interpret. The normal response in the noncomatose patient to cold in the right external auditory canal is nystagmus with the fast component to the left. This was not recorded in the protocol. Thus, we must assume the response was normal. The response on the left was clearly abnormal. No response signifies a destructive lesion in the pons. However, with such a lesion, the eyes should be tonically deviated to the left under the normal pressure exerted by the right vestibular nucleus. Thus, there are some incongruities. I think it is sufficient to say, however, that this patient had ample evidence of either multifocal or diffuse disease.

Coma indicated that either marked and diffuse cerebral disease was present, or that there was a localized lesion in the reticular activating system.

Let me mention at the outset that I think it very unlikely that metastatic carcinoma of the breast with carcinomatous meningitis is the diagnosis in this case. For one thing, fever and chills were present, an unusual finding in carcinomatosis. No premonitory symptoms had been noted over the past several months. Evidence of hepatomegaly, pulmonary, bony, and lymph node metastases was lacking. No atypical cells were seen in the CSF. The glucose was not low. Moreover, 10 years had elapsed since the diagnosis (although for breast cancer, metastatic disease is still possible).

The elevated glucose rules out hypoglycemic brain disease, but I doubt it was sufficiently elevated to produce a hyperosmolar state in the presence of a normal serum sodium.

A myocardial infarction followed by a mural thrombus, which disrupts producing showers of emboli, is distinctly unlikely because one would have expected discrete central nervous system (CNS) lesions (e.g., hemiparesis). Moreover, her course was not apparently complicated by arrythmia.

Which of these CNS findings relate to the patient's underlying renal disease itself? Mild defects of mentation are common with any significant degree of renal failure. These usually take the form of fatigue and slight irritability. With progression of renal failure, disorientation and confusion may become manifest. Asterixis, myoclonus, and fascicular twitching then often supervene, producing a syndrome of florid encephalopathy. Untreated, stupor and coma result, accompanied by increased deep tendon reflexes and hyperventilation. From the laboratory point of view, the EEG will become abnormal as the urea nitrogen rises above 60 mg/dl. Most commonly, it shows diffuse slowing with paroxysmal bursts of slow waves. The CSF is under an increased pressure (averaging 220 mm water). The protein ranges from 32-108 mg/dl, but the cell count is almost invariably normal. Fever is uncharacteristic of this syndrome.[1] This patient, though suffering from end stage renal disease, does not clearly fit the picture just described for several reasons. She had been clinically stable (we presume) on hemodialysis for the preceding 5 years. She deteriorated rapidly. No indication of myoclonic activity or twitching was given in the history. The patient was not hyperventilating. She was febrile. Her CSF was abnormal. Her urea nitrogen was moderately elevated at 97 mg/dl on admission.

Therefore, I shall not attribute these findings to underlying renal disease alone. (I must admit that if the underlying disease were systemic lupus erythematosus (LE) she could have presented exactly in this fashion, although I am given no antinuclear antibody, LE preparation, or history of that disease).

Next to be considered are problems the patient might have had related to hemodialysis itself. There are several complications of hemodialysis which are worth mentioning at this time. Restlessness, depression, and headache during dialysis are still fairly common. Seizures occasionally occur with rapid changes in blood biochemistry and pH (these are less common if hemodialysis is instituted on a less aggressive basis so that changes in blood pH and urea concentration are made gradually). A high efficiency dialysis may aggravate peripheral neuropathy.[2]

A particularly disturbing complication of

hemodialysis is **dialysis encephalopathy,** a syndrome characterized by the onset of stuttering speech, speech arrest, progressive alteration in mental function, and rapid deterioration to death. The EEG is non-specific, and the CSF is normal. Recent investigations suggest that this syndrome is caused by a persistant seizure focus in the thalamolenticular system.[3] Then there is a peculiar entity known as **dialysis dementia,** a slowly progressive deterioration in mental function associated with dyspraxia, bizarre involuntary movements, facial grimacing, and a supposedly characteristic EEG.

I shall attempt to dispose of these two diseases as possibilities in this case. (Or are they one?) No speech disturbance was reported. Although the deterioration in this patient was rapid, there was no dyspraxia, grimacing, myoclonus, or other involuntary movement noted. This patient's CSF was abnormal. Fever is not characteristic of dialysis dementia.

Another complication of hemodialysis is the so-called **dialysis-disequilibrium syndrome.** The pathogenesis involves the fact that urea is removed by dialysis more rapidly from extracellular than intracellular water. The result of this is an osmotic gradient pulling water into the cell. This may lead to cellular and especially cerebral edema. Usually occurring during dialysis, this syndrome is characterized by the following symptoms and signs: headache, vomiting, hypertension, convulsions, and coma. The problem is usually self-limited and occurs more readily in overly hydrated patients.[4] I do not think this syndrome characterizes this patient because it almost always occurs *during* dialysis. Furthermore, fever and pleocytosis in the CSF are not features, and one would expect an elevated CSF pressure, which was not present in this patient.

There are several complications of hemodialysis that are worth mentioning at this time.

The problem of subdural hematoma has been recently emphasized.[5] Fully 3.3% of individuals who are regularly dialyzed can be expected to experience this problem. The clinical picture is at times indistinguishable from the dialysis disequilibrium syndrome. The pathogenesis is multifactorial and may be related to increased intracranial pressure caused by cerebral edema, excessive anticoagulation, hyperosomotic dialysis with brain shrinkage and tearing of dural vessels, or hypertension. There is often a clear cut history of head trauma (sometimes minor). Marked changes in body weight or blood pressure are often noted between dialyses. These changes are usually brought about by dietary and fluid indiscretions on the part of the patient necessitating rapid removal of large amounts of fluid during dialysis. Although meningeal, focal, or multifocal neurologic signs may occur, this is unusual.

(The patient) had multifocal neurologic findings, including brain stem signs, without any evidence of increased intracranial pressure.

Subdural hematomas are best diagnosed by CT scan, brain scan (falsely negative in one-third), or cerebral angiography. Although subdural hematoma is a difficult diagnosis to make at times, and despite the observation that it occurs in individuals stable on hemodialysis, as in our patient, I regard this diagnosis as very unlikely because she was febrile. In addition, she had multifocal neurologic findings including brain stem signs without any evidence of increased intracranial pressure, and the CT scan was negative. She had a normal blood pressure. There was no history of rapid changes in osmolarity.

Because of the presence of fever and chills, infection was likely in this patient. Infection is very common in uremia especially when associated with hemodialysis. She had an elevated white blood cell count with a left shift. She had a mixed acid-base disturbance with a large anion gap — findings commonly noted in septic individuals.

Let me quickly dispose of some infections which I strongly doubt that she had. First, Rocky Mountain Spotted Fever (RMSF). This disease may well present with fever, chills, a macular eruption involving the extremities, progressing rapidly to coma. As in this case, carbenicillin would have no effect. In RMSF, the rash classically begins on about the 4th febrile day, and by the time the patient is comatose, it should have produced widespread vasculitis with innumerable diffuse skin lesions. We are not given the time of the year nor tick exposure history (70% have a positive history). Headache and myalgias were not part of this patient's history, and both are common in RMSF. Second, I consider meningococcemia unlikely, although this disease may also produce fever and chills and rapid coma. One would not have expected the patient to worsen on a penicillin derivative like carbenicillin. Additionally, this patient was somewhat old for this disease, and the skin lesions in meningococcal infections are usually petechial. Third, partially treated meningitis seems doubtful. This is possible, but I would have expected some history of headache, nuchal pain, or photophobia. Tuberculous or cryptococcal meningitis should be considered, but I doubt these diagnoses on the grounds that the onset is a bit sudden, the chest

film was normal, and the cell count in the CSF was atypical. Rigors are unusual in these diseases.

Viral encephalitis, which was a reasonable possibility in this patient, can be caused by a legion of microbial agents, but the disease is more common in children and is ordinarily self-limited except in the most extreme cases. Seizures are very common, however, in severe encephalitis (e.g., Herpes). In Herpes encephalitis, hemorrhages are often suggested by CT scan. Cytomegalovirus (CMV) infection is also common in the renal transplant-uremic population, but pneumonitis, hemolytic anemia, purpura, GI ulceration, and hepatitis are all more common than encephalitis. Toxoplasmosis was a possibility, but this usually occurs in the immunosuppressed host and is characterized by fever, lymphadenopathy, and hepatosplenomegaly; the latter two findings were notably absent in this individual.

Now I would like to turn to infections which I feel may be more germane to this case.

It is well known that infection is the major cause of death in acute renal failure and a common problem in chronic renal disease as well.[6] There is evidence that the reactivity of lymphocytes to phytohemaglutinin is blunted by the serum of uremic patients.[7] Leukocyte migration and phagocytosis have been found to be defective in this population as well.[8] Hemodialysis also increases the risk of infection. In fact, the mortality from infection in patients on maintenance hemodialysis ranges from 14-33%.

However, all febrile reactions in patients on hemodialysis are not necessarily related to infection. In fact, fever is quite common in patients on hemodialysis. The incidence is 0.53-0.96 times per patient-month.[9] That is, every patient who has had more than 10 dialyses has had one or more febrile reactions. Fortunately, most of these pyrexial reactions are self-limited. They are thought to be related to the passage of bacterial products (e.g., endotoxin) across the dialysis membrane. And since only 1 mg/kg of endotoxin in the bloodstream can produce fever, a major rupture in the membrane is not necessary.

A very difficult problem in the regularly dialyzed patient is that the presence of chronic renal failure may obscure the diagnosis of endocarditis.

Urinary tract infection is quite common in patients on hemodialysis.[6] We have evidence that this patient had a urinary tract infection. This could certainly produce sepsis and coma. There are several points, which to me, make this less likely. Two organisms were grown from the urine which suggests, but does not prove, contamination. There is evidence that patients who had repeated urinary tract infections (which I am taking the liberty to *assume* in this patient) are more tolerant to the organisms and less often septic from them. Gram-negative bacteremia per se does not often produce multifocal CNS signs and macular eruptions. Although I doubt its presence, I cannot exclude Gram-negative sepsis from a urinary tract source on the information given.

Hepatitis secondary to CMV has been described as a common infection in patients on hemodialysis, but we have no evidence of fulminating liver disease. Moreover, CMV infection is ordinarily not this aggressive, but produces a mild to moderate infection with hepatosplenomegaly and atypical lymphocytosis.

. . . this patient has a urinary tract infection. This could certainly produce sepsis and coma.

Next I would like to turn to access site infection. The first successful vascular access for chronic dialysis was the Quinton-Scribner external shunt. Use of this device was frequently complicated by both local and systemic infection with an incidence of 3.5 shunt infections per 100 patient-months.[10]

Arteriovenous (AV) fistulae were originally thought to be less often infected than shunts. The incidence of local infection *is* less. Unfortunately, the incidence of septicemia is *similar* to shunts. Indeed, serious infections complicating fistulae occur more often than with shunts. It appears that the type of fistula employed also makes a difference. In one study, sepsis occurred earlier and with greater frequency in patients with bovine heterograft fistulae than with Brescia fistulae.[10] Staphylococci continue to predominate in these infections, and the likelihood is increased if the patients are nasal or perineal carriers. Enterobacteriaceae and pseudomonads are also often involved. These organisms and others, like *Bacillus cereus,* can grow in the dialysate which recirculates and contains abundant nutrients to support bacterial growth. Thus, this patient was at great risk for a serious dialysis-related infection. How then does one make such a diagnosis? Infection in a shunt is rather easy to diagnose and local cellulites, thrombosis of the shunt, and bleeding are noted commonly. In contrast, almost one-third of patients with fistula infection have no local findings distinguishable from the inflammation accompanying regular use of the fistula.[10] Nonetheless, the usual symptoms and signs are fever in 80% (which our patient had), rigors in 45% (which our patient had), local swelling, tenderness, and erythema (especially with *S. aureus*). I think it is suspicious that a patient who had been on hemodialysis should enter the hospital and

be peritoneally dialyzed unless the access site was malfunctioning. Therefore, I am concerned about access site infection in this patient.

Let us proceed to the question of endocarditis.[10] In 1966, a relation between hemodialysis and endocarditis was first reported.[11] However, as early as 1957, Hook[12] described a patient with a traumatically acquired AV fistula who developed endocarditis. Furthermore, there are data from studies in laboratory animals which indicate that the circulatory stress resulting from AV fistulae enhances the susceptibility of the myocardium to infection. Therefore, the mere presence of an AV fistula may predispose to endocarditis.

Moreover, while transient bacteremia is common in everyone, it is likely more common in hemodialysis patients. It is therefore probable that an AV fistula may lead to the persistence of an otherwise transient bacteremia. This could much more easily seed the heart valves. Endocarditis is thus more common in patients undergoing hemodialysis. A very difficult problem in the regularly dialyzed patient is that the presence of chronic renal failure may obscure the diagnosis of endocarditis. Anemia, toxic encephalopathy, microscopic hematuria, and systolic heart murmur frequently seen in endocarditis are also frequently seen in chronic renal failure. Patients with uremia often have serious infection and yet are afebrile. When endocarditis and uremia coexist, it is well known that blood cultures may be sterile. The organisms involved are often *S. aureus, S. faecalis, P. aeruginosa,* and *S. epidermidis*. The aortic valve is most frequently involved.[13] The incidence of neurologic complications of approximately 30% in infective endocarditis is similar in both the acute and subacute variety.[14, 15] Moreover, the use of antibiotics has had no effect on this incidence.

This patient had several symptoms favoring a metabolic or septic brain disease.

Toxic symptoms associated with endocarditis and CNS involvement include headache, impaired consciousness, lethargy, drowsiness, insomnia, dizziness, and vertigo.[15] Because of the heart murmur described, this diagnosis is reasonable in this patient, although these are very nonspecific symptoms. Twenty-five percent of patients have cranial nerve findings with endocarditis. Virtually every lesion has been described. This woman definitely had mixed, widely separated cranial nerve signs. A common CNS complication of acute *and* subacute endocarditis is meningoencephalitis. In this condition, the nuchal rigidity may be minimal, as in this patient, or extreme. The CSF may be normal or show a marked pleocytosis with elevated protein (as in this patient). The glucose is usually normal, and the smears and cultures are negative (as in this patient), although admittedly the prior treatment with antibiotics does cloud the issue. When acute purulent meningitis is found, the organism is usually *S. aureus*.

The patient had several symptoms favoring a metabolic or septic brain disease. She had evidence of widely separated lesions (i.e., bilateral third cranial nerve dysfunction, abnormal vestibular nerve function, bilateral Babinski's sign), a neurologic syndrome not readily explained by a single lesion. In addition, the rapidly fluctuating neurologic status, diffusely abnormal EEG, and abnormal arterial gases do not favor a single structural lesion. These findings are quite compatible with endocarditis and its neurologic sequelae. Somewhat worrisome is the fact that cerebral hypoxia secondary to relative hypotension could explain most of the CNS picture. Patients with long-standing severe hypertension are relatively hypotensive at a pressure of 120/50, but I doubt these severe CNS findings would be manifest at this level of blood pressure, and I certainly would not expect hypoxia alone to produce pleocytosis in the CSF.

Factors affecting mortality from endocarditis in hemodialysis patients have been emphasized. Mortality is significantly increased when two valves are involved, an enterococcal infection is present, the patient is receiving corticosteroids, infection occurs in the first year of dialysis, affected patients are over 46 years of age, and the original source of the bacteremia persists.[13]

My diagnosis, therefore, is infective endocarditis, probably staphylococcal, secondary to vascular access site infection.

Discussion of Pathology

Autopsy was performed by Dr. Frank Winecoff. Dr. J. Robert Teabeaut, Dr. Farivar Yaghmai, and Dr. Lalla Iverson provided consultation. Results showed that the kidneys were reduced in size and weighed 100 gms. each. The majority of glomeruli were hyalinized with severe loss of nephrons presenting the picture of "end stage" renal disease. The comparatively better preserved glomeruli showed diffuse and nodular diabetic glomerulosclerosis (Figure 1), and occasional aneurysmal dilatation of capillaries (Figure 2). Afferent and efferent arterioles showed hyaline arteriolosclerosis, and mucinous intimal thickening was seen in arcuate arteries. Bloodworth[16] found these changes to be associated with an accelerated course of diabetic glomerulosclerosis leading to renal failure in about 11% of cases of adult diabetes and 50% of juvenile diabetes. He has related the development of the capillary microaneurysms to the accelerated course

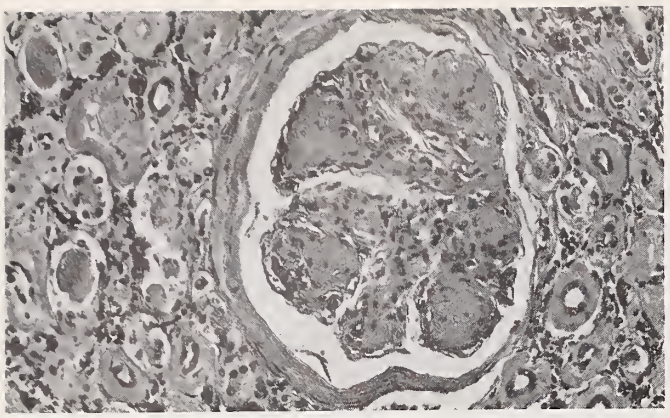


Figure 1 — Glomerulus showing the nodular lesions of diabetic glomerulosclerosis. Note the severe tubular atrophy. (Hematoxylin and Eosin × 75)

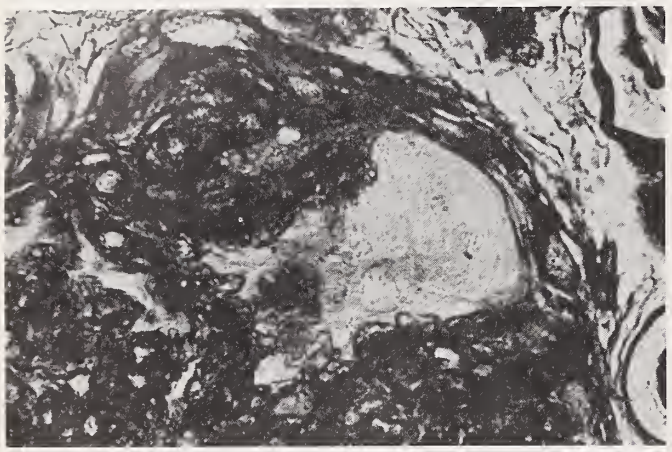


Figure 2 — Aneurysmal dilatation of a glomerular capillary. (Periodic acid-Schiff stain × 350)

and has suggested that the nodular lesions result from the organization of microaneurysms.

The heart was hypertrophied and weighed 450 gms. The posterior leaflet of the mitral valve showed a few "sea anemone-like" projections and was thickened. The annulus of the mitral valve showed calcification. An abscess 1 cm. in diameter was present on the epicardial surface adjacent to the left circumflex coronary artery 1 cm. distal to the origin of the anterior descending branch of the left coronary artery. Sections of the mitral leaflet and the abscess showed chronic suppurative inflammation, fibrosis, and pronounced calcification (Figures 3 and 4). *Acinetobacter Sp.* was grown in culture of the grumous contents of the abscess. Recent and old myocardial infarcts were present in both ventricles. Recent and old emboli were present in the intramyocardial branches of the coronary arteries and interestingly, many of these emboli were calcified (Figure 5). Several small infarcts, recent and old, were scattered in the basal ganglia, other areas of cerebral hemispheres, and in the brainstem. Some of the old infarcts were calcified (Figure 6). Calcified emboli were also present in the pulmonary artery branches.

The A-V graft in the arm was not examined. However, infection of the graft had probably occurred and may explain the calcified emboli in the lungs and the endocarditis. Calcification of emboli, such as was seen in this case, was noted in a previous



Figure 3 — Suppurative inflammation, fibrosis, and calcification of the posterior leaflet of mitral valve. (Hematoxylin and Eosin × 250)

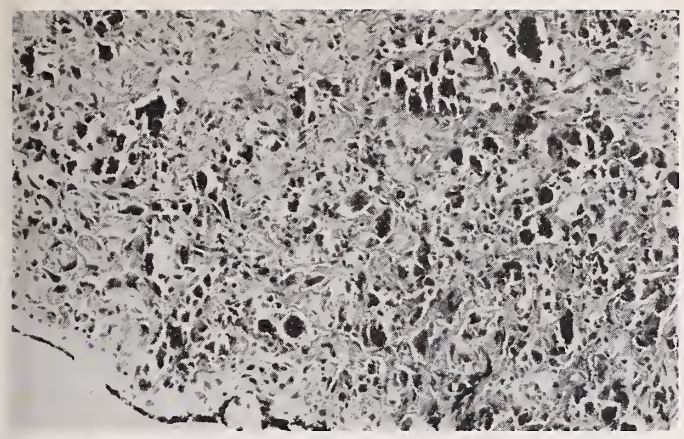


Figure 4 — Fibrosis and calcification of the abscess wall. (Hematoxylin and Eosin × 250)



Figure 5 — Calcified embolus in an intramyocardial vessel. (Hematoxylin and Eosin × 350)

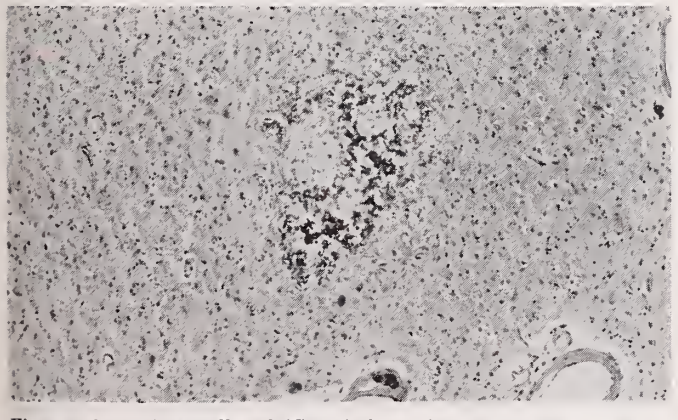


Figure 6 — A small calcified infarct in the cerebral cortex. (Hematoxylin and Eosin × 150)

case of endocarditis (ETMH Autopsy No. 5344), caused by *Moraxella Sp. Moraxella* and *Acinetobacter* have many common cultural characteristics. The calcification is perhaps related to some common biochemical characteristic of the organisms or more simply, may only reflect the low pathogenicity of the organisms and long duration of lesions. The pathologic evidence indicated the endocarditis to be of much longer duration than the clinical evidence of infection of about 10 days.

Pathologic Diagnosis:

Nodular and diffuse diabetic glomerulosclerosis, severe.

"End Stage" kidneys.

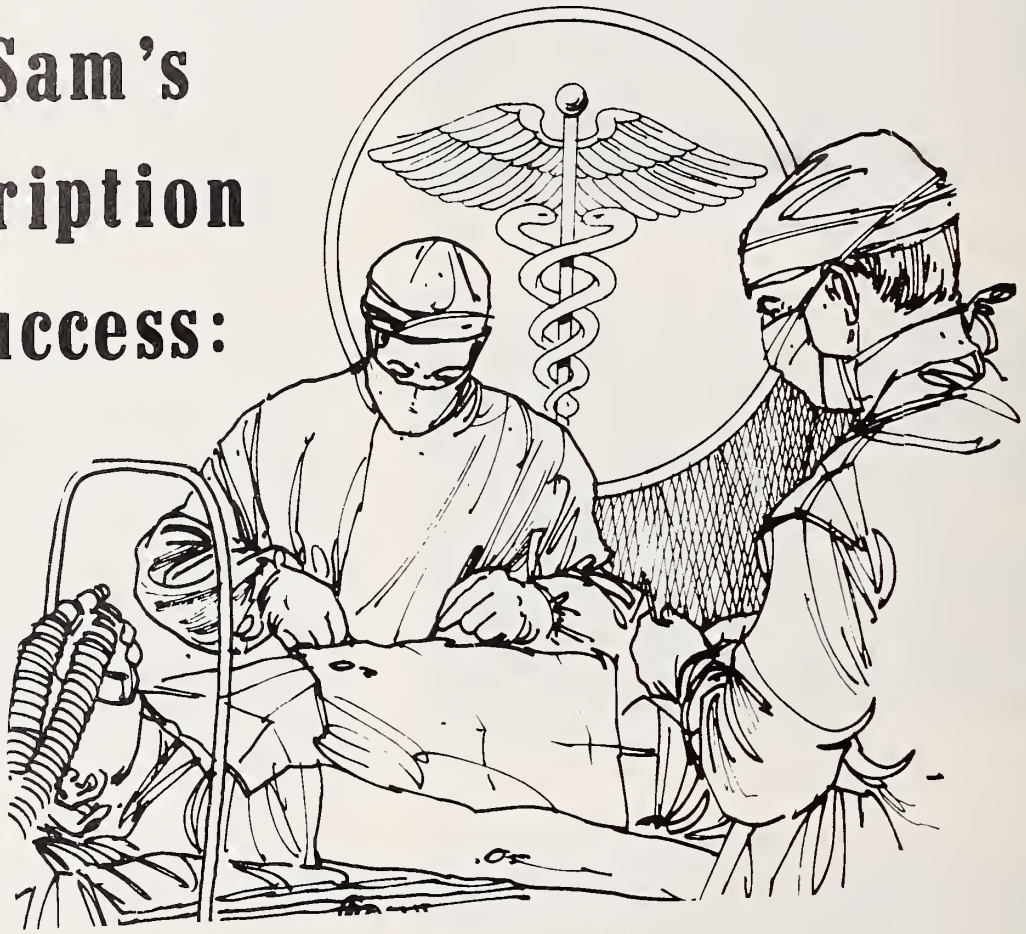
***Acinetobacter* endocarditis of mitral valve.**

Recent and old emboli and infarcts of heart and brain.

References

1. Tyler HR: Neurologic disorders in renal failure. Amer J Med 1968; 44:734-748.
2. Mawdsley C: Metabolic disorders and the nervous system. Proc Roy Soc Med 1972; 65:871-873.
3. Nadel AM, Wilson WP: Dialysis encephalopathy: A possible seizure disorder. Neurology 1976; 26:1130-1134.
4. Maher JF, Schreiner GE: Hazards and complications of dialysis. N Engl J Med 1965; 273:370-377.
5. Leonard A, Shapiro FL: Subdural hematoma in regularly hemodialyzed patients. Ann Intern Med 1975; 82:650-658.
6. Montgomerie JZ, Kalmanson GM, Guze LB: Renal failure and infection. Medicine (Baltimore) 1968; 47:1-32.
7. Newberry WM, Sanford JP: Defective cellular immunity in renal failure: Depression of reactivity of lymphocytes to phytohemagglutinin by renal failure serum. J Clin Investig 1971; 50:1262-1271.
8. Clark RA, Hamory BH, Ford GH, et al.: Chemotoxin in acute renal failure. J Infect Dis 1972; 126:460-463.
9. Robinson PJA, Rosen SM: Pyrexial reactions during haemodialysis. Brit Med J 1971; 1:528-530.
10. Dobkin JF, Miller MH, Steigbigel NH: Septicemia in patients on chronic hemodialysis. Ann Intern Med 1978; 88:28-33.
11. Brescia MJ, Cimino JE, Appel K, et al.: Chronic hemodialysis using venipuncture and a surgically created arteriovenous fistula. N Engl J Med 1966; 275:1089.
12. Hook EW, Wainer HS, McGee TJ, et al.: Acquired arteriovenous fistula with bacterial endarteritis and endocarditis. JAMA 1957; 164:1450-1454.
13. Cross AS, Steigbigel RT: Infective endocarditis in patients on hemodialysis. Medicine 1976; 55:453-466.
14. Jones HR, Sukert RG, Geraci JE: Neurologic manifestations of bacterial endocarditis. Ann Intern Med 1969; 71:21-28.
15. Harrison MJG, Hampton JR: Neurological presentation of bacterial endocarditis. Brit Med J 1967; 1:148-151.
16. Bloodworth JMB Jr: A re-evaluation of diabetic glomerulosclerosis 50 years after the discovery of insulin. Human Path 1978; 9:439-453.

Uncle Sam's Prescription For Success:



Medicine and the Ga. National Guard

As a physician in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found...service to community, state and nation.

In addition, many persons have found that the change of place and change of pace have resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for the Georgia Army National Guard units. Physicians receive monetary support for attending approved CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. **WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS.** If you need that **CHANGE OF PLACE** and **CHANGE OF PACE**, contact:

ARMY NATIONAL GUARD
The Guard belongs.

Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662

Viral Hepatitis Outbreaks — Georgia, Alabama*

TEN RECENT CASES of probable hepatitis A associated with consumption of raw oysters from Florida have been identified in Albany, Georgia, and Mobile, Alabama.

An investigation of three Albany residents in whom hepatitis was diagnosed during the week of October 28 disclosed that two had eaten raw oysters on October 13, and the other had eaten raw oysters on October 15. The oysters had all come from a single sack purchased in Florida.

An investigation of five Mobile residents with onset of hepatitis from November 5-7 found that their only common exposure was having eaten raw oysters at a club dinner on October 11. Two other Mobile hepatitis patients who had eaten raw oysters purchased from the same store at the same time as the oysters purchased to serve at the club dinner, were also identified.

The Food and Drug Administration, the Center for Disease Control (CDC), and state and local health authorities are trying to trace the source of the oysters for both outbreaks. Preliminary results suggest that the oysters came from a single area in Florida. The investigation is continuing.

* Reprinted from Volume 28, Number 49, of the *Morbidity and Mortality Weekly Report*, Center for Disease Control, Atlanta.

Reported by D Smith, Georgia Dept of Human Resources; J Cutts, DVM, Mobile County Health Dept; T Chester, MD, State Epidemiologist, Alabama Dept of Public Health; R Gunn, MD, State Epidemiologist, Florida Dept of Health and Rehabilitative Services; U.S. Food and Drug Administration; Enteric Diseases Br, Bacterial Diseases Div, and Epidemiology Section, Hepatitis Laboratories Div, Bur of Epidemiology, CDC.

Editorial Note: Raw oysters have been implicated as the vehicle for transmission of hepatitis in several outbreaks in the United States, most recently in 1973, when 285 people became ill after eating raw oysters harvested in Louisiana.[1] The number of cases involved in the two outbreaks reported here is small compared with such previous outbreaks, although there may be cases which have not yet been identified. **Physicians are urged to report all cases of hepatitis to the appropriate public health authorities and to be particularly alert to possible oyster-associated cases.**

Reference

1. Portnoy BL, Mackowiak PA, Caraway CT, Walker JA, McKinley TW, Klein CA: Oyster-associated hepatitis. Failure of shellfish certification programs to prevent outbreaks. JAMA 233:1065-1068, 1975.

Criteria for selection and techniques for usage are discussed.

Use of Eye Bank Sclera in Plastic and Reconstructive Surgery

RALPH E. WESLEY, M.D., *Nashville,* JANIE BENSON, and CLINTON D. McCORD JR., M.D., *Atlanta**

Introduction

THE INCREASING SUCCESS of corneal transplants to restore sight to needy individuals has led to the development of the Georgia Lions Eye Bank. This eye bank conducts research programs into corneal preservation, ocular physiology, glaucoma, and cataract surgery at Emory University School of Medicine in Atlanta and the Medical College of Georgia in Augusta. An important by-product of the eye banks has been the availability of eye donor sclera for the use in ophthalmic plastic and reconstructive surgery.

Technique for Obtaining Donor Sclera

When an eye is donated to be used in the transplant program, only the clear cornea in the anterior of the eye is used. When the intraocular contents consisting of retina, uvea, lens, and vitreous are then removed, what remains is a tough, fibrous, white, nearly acellular outer coating of collagen of the eye called the sclera. To provide donor material, the sclera is dehydrated in glycerol using a molecular sieve; it turns from white to a brownish opaque color. Donor eye bank sclera can be stored for months without refrigeration for use in plastic and reconstructive surgery.

Transplant Operative Technique

At the time of operation, the donor sclera is rehydrated by soaking for a few minutes in an antibiotic solution in which it returns to its normal white appearance. Donor sclera has been used extensively over the years without encountering the problems of migration, infection, and rejection that have occurred with synthetic materials such as methyl methacrylate, silicone, and proplast.

Use of eye bank sclera does not require an additional operative site as does the use of fascia lata or dermis-fat grafts. Nor does eye bank sclera tend to reabsorb if it is buried subcutaneously. It is supplied in a roughly spherical shape with a diameter of approximately 2.5 cm. Donor sclera can be cut and trimmed as desired.

Uses of Donor Sclera

Uses of donor sclera in plastic and reconstructive surgery are varied. In patients with retracted upper eyelids from thyroid disease, with overcorrection following ptosis surgery for droopy lid, or with internal scarring in the upper lid, donor sclera can be used to lower the lid to provide a more normal appearance and to allow the upper lid to preserve sight by protecting the cornea. A strip of sclera is inserted into the upper lid between the tarsus and the tendons which move the upper lid. This allows the upper lid to come down to a normal position just as one would add extra lengths to a chain. In patients with thyroid eye disease, it may also be necessary to do this to the lower lids to correct lid retraction.

Donor sclera has been highly useful in the rehabilitation of patients who have lost an eye. Usually, when an eye is removed, a plastic sphere is placed in the orbit to replace the lost volume. Connective tissue (tenon's capsule) and conjunctiva are

* Dr. Wesley is the former Clinical Instructor and Fellow in Ophthalmic Plastic Surgery, Ophthalmology Section at Emory University. He is now the Director of Ophthalmic Plastic and Reconstructive Surgery, Department of Ophthalmology, Vanderbilt University Medical Center. Ms. Benson is the Executive Director of the Georgia Lions Eye Bank at Emory University. Dr. McCord is Clinical Professor of Ophthalmology and Director of Ophthalmic Plastic and Reconstructive Surgery, Ophthalmology Section, Emory University. Direct reprint requests to Dr. Wesley, Department of Ophthalmology, Vanderbilt University Medical Center, Nashville, TN 37232.



Figure 1 — Patient with loss of entire right upper lid due to human bite. Upper lid remnants had been sewn to lower lid.



Figure 2 — Rehydrated eye bank sclera (white) was used in reconstruction of upper lid to add substance and stability.



Figure 3 — Post-operative reconstructed upper lid using eye bank sclera in Cutler-Beard technique. Stable lid margin allowed patient to wear artificial lashes.

sewn over this, and the prosthetic eye is then fitted. Unfortunately, patients who have lost an eye at an early age or have experienced trauma to the orbit are often unable to wear an artificial eye, because the implanted plastic sphere later migrates within the orbit or extrudes outward. Donor sclera, with its fibrous, tough consistency, can be used to reinforce the connective tissue layers of the orbit, so that the plastic implant is held in the proper position. In addition, eye bank sclera can now be used at the time of the original enucleation to reinforce the connective tissue layers of the orbit. The use of donor sclera has allowed many patients to wear a prosthetic eye and to return to their normal lifestyle.

In patients missing an eyelid from trauma (Figures 1-3), tumor, inflammation, or congenital defect, sclera can be used as a replacement for the tarsal plate. Using donor sclera in eyelid reconstruction gives a more normal appearance to the reconstructed eyelid and increases the stability to the lid margin to prevent keratinized skin from rotating under and scratching the sensitive cornea.

Sclera can be placed subcutaneously around the face to correct depressions with a more predictable effect than the dermis-fat graft. Donor sclera can therefore be used in "touch-up" work where other conventional methods would be unsuitable. Every ophthalmologist should have eye bank sclera at his disposal for cases of eye trauma in which portions of the patient's own sclera have been lost. Eye bank sclera can be used in this emergency to repair the eye and save vision.

Contraindications

Contraindications to the use of an eye for scleral transplantation in plastic and reconstructive surgery include recent overwhelming septicemia, history of syphilis, hepatitis, malignant ocular tumors, or certain viral infections such as rabies. (The presence of a malignant tumor in the posterior of an eye does not prohibit the use of the cornea for transplantation.) History of eye disease or the use of glasses in no way rules out an eye for transplantation. Sclera from persons of any age can be used. Tissue from older persons is actually preferred because it tends to be more rigid and thus provides better strength and stability.

The donation of eyes to the Georgia Lions Eye Bank not only restores vision to many individuals but also, through the use of eye bank sclera, helps many persons return to work, school, and a normal lifestyle without disfigurement. As technology of eye bank sclera is more widely disseminated, surgeons in other specialties will undoubtedly find additional uses for this material.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

Serving the General Insurance needs of
the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

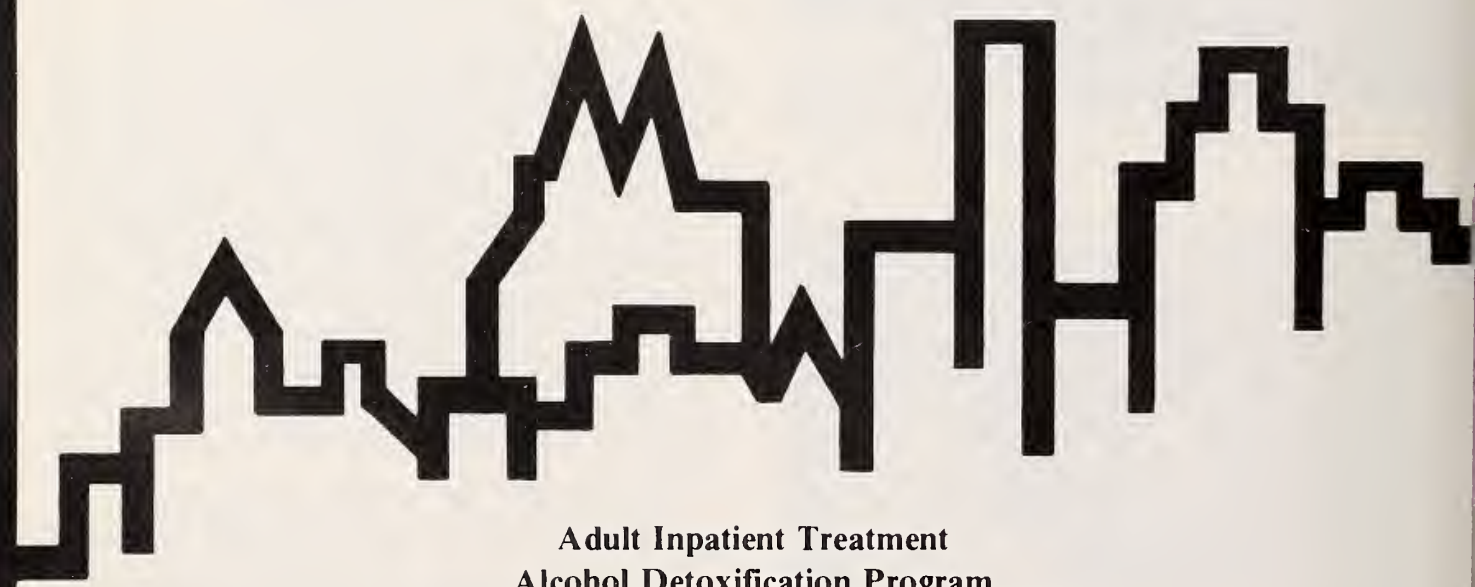
3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR INSURANCE AGENT

Specialized Health Care in the Heart of Atlanta



Adult Inpatient Treatment
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

Psychiatric Institute of Atlanta • 811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

It is important to recognize the powerful psychologic variables at work in the burn patient's reactions, recovery, and management.

The Seriously Burned Adult: Psychologic Reactions, Recovery, and Management

C. DAVID TOLLISON, Ph.D., JOSEPH M. STILL JR., M.D., and JOSEPH W. TOLLISON, M.D., *Augusta**

To be extensively burned is to suffer one of the most devastating and dehumanizing injuries a human can experience. One challenge to the health care team involves helping both the patient and his family adjust to the monumental psychologic stress of an acute and traumatic change of life style. It is important that the patient and family members, as well as the health care team, be able to identify and understand the various adaptive problems and coping mechanisms experienced by the patient during his hospital course and to understand those treatment methods available to ease tensions and provide a more satisfactory convalescence. Each trauma resulting in physical disability possesses its unique constellation of threats to the personality and precipitates a variety of complicated psychologic problems — perhaps different in each patient. They may involve incidents surrounding the accident, the basic personality of the patient, and the extent and type of injury. Nevertheless, most severely burned patients experience adaptive and coping problems that are basically similar, and an effective understanding and management of these by the patient, his family, and the staff facilitates both the short and long-term rehabilitation of the patient.

* Dr. David Tollison is a psychologist in private practice. Dr. Still is a plastic surgeon. Both are in Augusta. Dr. Joseph Tollison is from the Department of Family Practice, Medical College of Georgia (MCG) in Augusta. Direct reprint requests to Dr. Joseph Tollison, Department of Family Practice, MCG, Augusta, GA 30912.

Modes of Reaction

How an individual reacts emotionally to the physical impairment, disability, and pain of a traumatic burn depends on various factors. What does the disability mean to him? What are the short and long-term reactions of his family, friends, employer, etc.? Does the accident represent a threat to his control over the environment resulting in a perceived state of helplessness? Does his post-burn physical disfigurement represent a threat to his concept of himself as masculine (or, in the case of a woman, feminine)? Perhaps the impairment and disability signifies a socially acceptable means of escaping from a maladaptive or conflicting life-struggle, or possibly the injury is perceived as punishment for sins, real or imagined. Regardless of the patient's perception of his injury, the emotional reaction of most burn patients will depend largely on the techniques used for dealing with stress that the individual has developed since childhood and which have been important in his development. These include:

1. **Denial:** The burn patient may deny physical impairment or disability — a rather gross departure from reality, or, more commonly, he may deny the significance or affect associated with the injury. Thus, his behavior expresses the idea, "I am not really injured that badly" or, "I may be disabled and/or disfigured, but I am not concerned or upset." Denial is a defensive mechanism for controlling anxiety and is a useful component in the rehabilita-

tion process as long as it does not interfere with the therapeutic treatment or permanently mask reality.

2. **Anxiety:** There are probably few sources of anxiety more significant than the awareness that one's continuance is threatened. The knowledge that one has been so close to death and the fear of a recurrence may understandably trouble the burn patient. Anxiety may also surface as a result of perceived helplessness to combat the physical impairment and pain as well as the destruction of a perception of invulnerability.

3. **Depression:** Depression, as well as anxiety, may be a reaction to "learned helplessness." Learned helplessness may be thought of as the realization that the patient has lost control over his environment and, at least in the early stages of treatment, must play a passive, almost totally recipient role to numerous doctors and staff. Loss of control and forced passivity may further magnify feelings of danger and dread originally initiated by the so-called "destruction of invulnerability." Depression may also be a reaction to the physical loss of bodily functions and should be considered a normal reaction to an incapacitating burn. In fact, if depression does not become evident at some point in the rehabilitation process, the staff should be aware that the patient may be utilizing denial or the satisfaction of some inner psychologic need (e.g., self punishment, punishment of others, dependency).

4. **Withdrawal:** Closely related to the reaction of depression is that of withdrawal. The burn patient, rather than coping actively with the challenge of reality and rehabilitation, may consciously or unconsciously react with profound apathy and passivity, closely imitating the helpless behaviors and characteristics of a young child.

5. **Hostility:** Hostility is probably the most common reaction to a serious burn injury and frequently causes staff members the most alarm and concern.[1] Hostility may be expressed inwardly — "What did I do to deserve this? I can't believe I let myself be so stupid as to get injured"; or outwardly — "It is not my fault that I hurt so badly; it's their fault, doctors and nurses; their incompetency is responsible for my pain." The inward expression of hostility may closely parallel the reaction of depression and withdrawal. The outward expression of hostility is probably more common, and doctors, nurses, and staff are primary targets due to their frequent contact with the patient and to the fact that many treatment procedures of the burn patient are indeed painful (e.g., surgery, dressing changes, physical therapy). The outward ventilation of hostility enables the patient to express his dissatisfaction and discontent in such a way as to demand at least a mutual sharing of responsibility for his distress which is thought to reduce anxiety.[2]

6. **Regression:** The seriously burned patient, facing a lengthy rehabilitation period during which he may be unable to rely on physical and personality resources, may regress or revert to coping techniques found successful during earlier periods in his life. He may attempt to control, manipulate, or angrily punish staff members by using obstinance or gamesmanship as he did as a young child. Recalling early sibling rivalry he may become covertly or overtly seductive or solicitous to doctors and nurses and become jealous of the attention and care extended to other patients. A more extreme regression is manifested by gross dependency and depression, a desire to be cared for, and pleadings for acceptance and attention. Excessive dependency may be noted in two superficially dissimilar personality types: (1) the individual who has a history of dependency in whom the disabling burn injury is merely a specific and demonstrable reason for continued dependency; and (2) the chronically dependent individual who has never allowed expression of his dependency needs. With the latter type of individual, burn injuries and disability may evoke a multitude of previously repressed needs.

7. **Healthy Adaptation:** Some individuals may accept the reality of their condition and work in constructive, appropriate, and goal-oriented activities toward recovery of functions. Other modes of reaction described may occasionally occur to a minor degree but are followed by renewed acceptance of the rehabilitation challenge.

Stages of Recovery

The burn patient faced with temporary or permanent impairment, loss of bodily functions or parts, numerous surgeries, and long-term rehabilitation goes through a succession of adjustment stages. Each of these stages enables the patient to psychologically process and manage a diversity of emotions. Individual differences do exist, with some remaining in certain stages longer than others, and with others skipping a stage entirely. Most patients, however, manifest a similar progression of adaptation stages.

1. **Shock:** The first stage of adaptation is marked by a wide diversity of behaviors, including attentiveness and unimpaired cognitive functioning associated with a near "super normalcy," complete

emotional withdrawal, agitation, and uncontrolled emotion. Each of these behaviors may be considered regressive reactions by which intolerable pain and the emotional flood of feelings are either blocked from consciousness or diverted.

2. **Denial:** After personality resources have had time to reorganize, restitution via denial occurs. As previously mentioned, the patient may deny the actual occurrence of burn injuries or, more commonly, may deny the extent or affect associated with the injuries. Denial is a defense mechanism against overwhelming anxiety. To challenge the patient with the reality of his condition too early may disrupt the tenuous emotional balance established by this defense. Consistent support and gradual reality confrontation is most therapeutically effective during this recovery stage.

3. **Agitated Consciousness:** This stage of recovery is most commonly, although not exclusively, exhibited by younger patients or those individuals who have not learned to control or sublimate their aggressiveness and hostilities. The patient for the first time faces the reality of his physical condition which results in either intense internal distress (agitated depression) or external distress (anger, manipulativeness). Intrastaff conflicts and disagreements are quickly perceived and may be used by the patient to project his hostilities away from himself. This is likely to represent the most frustrating and trying period for staff members who frequently fall victim to the patient's manipulative skills. For the patient, this period represents a critical stage of recovery, and consistent efforts by all staff members will facilitate the patient's progression. Firm and consistent limits on the patient's behavior should be imposed by the staff, and yet, at the same time, they should remain supportive and understanding.

4. **Working Through:** While this is the longest stage of recovery, it can be an enjoyable experience for both the patient and the staff. If the previous stages have been managed successfully, the patient should enter into a therapeutic alliance with the staff against his disability. During this stage, the patient recognizes and comes to appreciate the efforts of his doctors and other staff members. He explores reality, occasionally retreating into areas of frustration but progressing further toward rehabilitation.

5. **Separation Anxiety:** Prior to hospital discharge, the patient may briefly exhibit a recurrence of agitation similar to that seen in the third stage. The patient realizes he must face the outside world, and he may not have been restored to his pre-injury status. This is especially true when the patient suffers from visible disfiguration. Increased support and understanding along with family counseling facilitates the ease of separation from the protective and accepting hospital environment.

6. **Coping:** During this stage, the patient gradually tests the environment, including the reaction of home and community. Successful coping depends, to a great extent, on self acceptance facilitated during hospitalization and the acceptance of family, friends, and society.

Treatment Techniques

1. **Patience, Tolerance, and Understanding:** These qualities are most important during the early stages of recovery when the patient is fighting internal turmoil and uncertainty. Gentle and supportive persuasion should be targeted toward encouraging the patient to ventilate feelings, but care shold be taken to avoid pressuring the patient to verbalize his concerns and fears.

2. **Education and Orientation:** Demonstrating to the patient that there is a predictable and structured course toward his recovery inspires trust and confidence. Imparting knowledge to the patient about future surgeries and the patient's general course of rehabilitation helps him confront reality gradually and become aware of those areas in which recovery of function can or cannot be expected.

3. **Transferring Control:** As the patient improves, efforts should be targeted toward helping him transfer from a state of dependency to a state of increased control of his life. He should be consulted in matters affecting his treatment program, and his input regarding feelings and ideas should be encouraged and respected.

4. **Reorientation:** When the patient's progress warrants it, efforts should be made to reorient him from passivity to activity. The restoration of function should be emphasized while the loss of function is deemphasized. The patient should be encouraged to become more active and to be less dependent on staff members. Increasing family support is also encouraged. All approximations toward this goal should be reinforced with verbal praises and attention from the doctor and staff.

5. **Psychotherapy:** Initially, psychotherapy should emphasize support to assist the patient in gradually accepting his condition. Meanwhile, carefully monitor signs that the patient's defenses have reorganized in such a way as to permit the acceptance of the long-term recovery campaign. Opportunities to ventilate frustrations, depression, and anger are critical if the patient is to work through

the trauma and accept his future medical course. Coping techniques should be explored as should the effects of his injury on family members, friends, and occupation.

Summary

The team approach to the treatment of severely burned individuals has been documented as effective in the total rehabilitation of the patient.[3] In such an approach, the emotional rehabilitation of the patient and his family is normally the direct responsibility of the team clinical psychologist or psychiatrist. By definition, however, the team approach denotes not only the efforts of various specialists working together toward a common goal but also a sharing of knowledge and expertise among team members. The patient's personal physician should be incorporated into the rehabilitation team, so that continuity of care and long-term support of the patient may be emphasized. In the team approach treatment of the seriously burned patient, it is important that all doctors and staff having contact with the patient and/or family recognize the powerful psychologic variables at work in the patient's reactions, recovery, and management.

References

1. Roberts ML, Pruitt BA: Nursing care and psychological considerations. In Artz CP, Moncrief JA, Pruitt BA (Eds.), *Burns: A team approach*. Philadelphia: WB Saunders, 1979.
2. Freud S: *Fixation upon trauma: The unconscious*. New York: Washington Square Press, 1963, pp. 284-296.
3. Artz CP: The team approach to the treatment of burns. In Artz CP, Moncrief JA, Pruitt BA (Eds.), *Burns: A team approach*. Philadelphia: WB Saunders, 1979.

TEST DRIVE THE LUXURY COUPE THAT'S AS EXCITING TO DRIVE AS IT IS TO SIT IN.

Get our quote on your next lease. No leasing company can beat our rates. Nobody can beat our service. Lease or purchase your car from us and be assured of "no hassle" service. Our customers come first.

Leasing and Sales.





GLOBAL IMPORTS

225 PHARR ROAD, N. E. / ATLANTA, GEORGIA 30305

TELEPHONE: (404) 261-9730

editorial
editorial
editorial

Health Versus Radiation Hazard

THE NUCLEAR incident at Three Mile Island has created widespread speculations and has polarized opinions either to those of knowledgeable nuclear scientists or to those of near-fanaticism created by the daily news stories. Amid ignorance and compelling emotions, the danger of even minimal potential low-level radiation exposure dwarfs our pressing economic concerns and the impact of vastly reduced energy.

At the annual meeting of the Radiological Society of North America in Atlanta in December 1979, a large exhibit was conspicuously placed in the hallway leading to the scientific exhibits. It featured the front page of the "Philadelphia Inquirer" which recounted dramatically for 14 consecutive days the progress of The Three Mile Island incident with foreboding headlines. Clearly suggested was that those people in the area who were not immediately annihilated by some holocaust reminiscent of the Hiroshima and Nagasaki nuclear bombs would surely slowly and grotesquely disintegrate. No such catastrophe occurred. Precautions for nuclear wastes are recognized and are being practiced. The news media neither limited their referral to the dangers of radiation to a mere 14 days nor omitted the constant reminder that medical radiation, nuclear-powered reactors, and nuclear weapons of vast destruction have similar characteristics.

Based on the agreement of genuine responsible radiation experts, Robert D. Mosely Jr., M.D. (*Applied Radiology,* Nov./Dec. 1979), a longtime member of the American College of Radiology Committee on Radiologic Units, Standard and Protection, summarized the greatest possible effect on the 2,000,000 population in nearby Eastern Pennsylvania subject to potential exposure.

Normally during the entire lifetime of this population, one would anticipate the development of 365,000 cases of cancer. Calculations of the greatest estimates of radiation exposure and the most radical estimates of radiation effect indicate that over the next 30 years, 365,010 cases of cancer might occur. The 10 added cases would be only the increase in the incidence of cancer and not the number of fatalities.

Using data from the Office of Technology Assessment, Dr. Peter Breckman (*Access to Energy,* July 1979), estimated that one coal-related death per week would result in replacement of the Three Mile Island energy with that produced by coal-fired plants. Natural sources of radiation, the largest level to mankind, have been ever-present in our food, our bodies, in all our surroundings. Many parts of Pennsylvania have higher background radiation than the normally occupied areas at Three Mile Island.

As physicians, we have cultivated a reliance on refereed scientific reports, with their unbiased validation and interpretation of scientific data by valued experts. As concerned members of our communities, we recognize that there must be an overall balance between health and hazard just as we encounter in the practice of medicine. We radiologists who are professionally involved with large quantities of radiation

in the diagnosis and treatment of our patients recognize the potentially lethal nature of radiation. We are constantly re-enforcing and expanding our knowledge. Yet there is a point at which we must look to and accept the opinions and recommendations of world respected bodies, such as those formulating standards for the protection of the human race from exposure to radiation, while maintaining the necessary energy to live comfortable and meaningful lives. We must use such conscientious guidelines formulated with indifference to the sensationalism created by the mass media or the hysteria of banner-waving minority groups. The austerity of deprivation of energy and the undermining of our economy must be faced without procrastination. Judicious use of energy must be coupled with renewed efforts to increase our sources. This logically includes expansion in the use of nuclear energy.

Robert L. Egan, M.D.
Chief, Mammography Section
Emory University, Atlanta

Homeward Bond.

The road to buying a new home can be difficult. But United States Savings Bonds can make the journey a lot easier.

All you have to do is join the Payroll Savings Plan where you work.

That way, a little is set aside from each paycheck to buy Bonds. Automatically.

You'll be amazed how quickly they pile up. Before you know it, the Bonds have built you a nice down payment. And you can build a nice, new home.

If you've been trying to save for a new home, buy U.S. Savings Bonds.

And get your savings headed in the right direction.

Take stock in America.

UNITED STATES SAVINGS BONDS

Ad Council A public service of this publication and The Advertising Council.

Reconciling the Antitrust Laws and the Health Care Laws

ROBERT N. BERG, *Atlanta**

As THE TITLE to this article suggests, the antitrust laws and the laws with respect to health care services are not in perfect harmony with each other. The antitrust laws, on the one hand, are aimed at and require free and open competition and prohibit most types of concerted, anticompetitive activity. The health care laws, on the other hand, in some instances, encourage the elimination of competition, through means such as sharing of services and joint planning activities, with the purpose of avoiding duplicity of health care services and reducing health care costs. It is thus apparent that the "free competition" model of the antitrust laws and the "cost containment" model of the health care laws are on a collision course. What is not so apparent, however, is the extent to which these two laws can be reconciled and the willingness of the courts to do so.

An Example — Mandated Joint Planning Activities

Although it is beyond the scope of this article to describe every aspect of the conflict between the antitrust laws and the health care laws, an example of that conflict and of the analysis employed both by the courts and by others in reconciling this conflict should serve to highlight some of the types of problems and possible solutions which may arise in this area.

One of the most controversial of the recent wave of health care statutes is the National Health Planning Resources and Development Act of 1974 (the "Act").[1] Under this Act, each state is required to have a certificate of need (CoN) law, pursuant to which certain capital expenditures (such as the construction or development of a new health care facility) could not be made without first obtaining a CoN. A CoN is issued only after an intensive review of the need for and appropriateness of the particular expenditure. In that context, the first level of review is performed by local semi-regulatory bodies called health systems agencies (HSAs), which are authorized, among other things, to develop review criteria to determine the appropriateness of and the necessity for the proposed capital expenditures.

The local HSAs, in establishing these review criteria, often require an applicant to undertake activities which may involve potential violations of the antitrust laws. For example, local HSAs may require that health care facilities show that they have engaged in joint planning with other facilities or institutions in their area in order to evidence the necessity and appropriateness of the proposed capital expenditures.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

While this criteria may serve to cut down on unneeded or inappropriate capital expenditures, it also imposes a duty upon the hospital or health care institution, when viewed realistically, to engage in collective activity with other hospitals in the area, its competitors, for the purpose of eliminating excess services or facilities. In antitrust parlance, this type of concerted activity is termed a "horizontal allocation" of services or facilities, and such activity is generally *per se* illegal[2] under §1 of the Sherman Act.

Thus, the conflict between the health care laws and the antitrust laws is created: health care laws aim to reduce health care costs through joint planning activities, while antitrust laws aim to increase competition by restricting joint planning activities.

Present Reconciliation of the Conflict

To date, two courts have expressly dealt with the question of whether or not the general review process associated with CoN reviews could constitute violations of the antitrust laws. In *Huron Valley Hospital, Inc. vs. City of Pontiac,*[3] a hospital was denied both a state CoN and approval under §1122 of the Social Security Act, the federal "capital expenditure review" program. Thereafter, the hospital brought an action against both the local HSA and certain other state and federal agencies alleging that these agencies conspired to restrain trade and create a monopoly in the provision of health care services through the use of the review processes. The basis for the suit was the fact that the plaintiff hospital's application to construct a hospital had been denied by the local HSA, while another hospital had been authorized to make certain capital renovations. Thus, the plaintiff hospital claimed that the review process had resulted in a "horizontal allocation of beds" and was a conspiracy to exclude the plaintiff hospital from the relevant health services market.

The District Court for the Eastern District of Michigan disagreed, however. That Court held that the CoN review activities were "within the ambit of valid federal and state legislation, and as such . . . exempted from the antitrust laws under the 'state action' defense. . . ." (The "state action" defense immunizes from attack under the antitrust laws activities which are compelled or mandated by state law.) Thus, in the *Huron Valley* case, the fact that the activities undertaken by the HSA were compelled by the Michigan CoN statute served to exempt the defendants from liability under the antitrust laws. In addition, the Court in *Huron Valley* held that the review process, as established under the Act, was intended by implication to repeal partially the federal antitrust laws, in that the inevitable effect of the health planning process was to restrict or restrain competition.

This second reason was also adopted by the District Court for the Western District of Missouri in a second case dealing with the reconciliation of the antitrust and health care laws, *National Gerimedical Hospital and Gerontology Center vs. Blue Cross of Kansas City.*[4] In that case, a private geriatric hospital brought an antitrust action against Blue Cross, alleging that Blue Cross conspired to boycott the plaintiff hospital and to coerce Blue Cross subscribers to refuse to deal with that hospital by adopting a higher reimbursement rate for hospitals obtaining CoNs than for hospitals not having CoNs. The Court dismissed the hospital's action, however, finding that the Act implicitly repealed the application of the federal antitrust laws, stating that "voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act." The Court also reasoned that, if it were to hold that private business working in conjunction with the local HSA to achieve the goals of the Act could be liable under the federal antitrust laws for their actions, then the accomplishment of the purposes and goals of the Act would be effectively foreclosed. Consequently, the Court held that Congress intended that actions taken pursuant to the Act and clearly within the scope of the Act would be exempt from application of the antitrust laws.

Despite the holdings in the *Huron Valley* and the *National Gerimedical* cases, there is support for the position that the "joint planning" requirements, whether or

not authorized under the Act, could constitute violations of the antitrust laws. For example, the Virginia Attorney General has refused to sanction a plan whereby a medical society and certain hospitals in a local health systems area could meet and address the issue of determining the needs in that health systems' area for beds and for obstetrical services. The reason for the Attorney General's refusal was his belief that the meetings would result in the allocation and reduction of beds among the hospitals in the health system area, in violation of the state antitrust laws.

Similarly, the Attorney General of the United States has failed to issue a business review letter in connection with an application for clearance presented by certain hospitals in Virginia. In that situation, the local HSA scheduled meetings among the area hospitals for the purpose of discussing allocation of services among existing area hospitals. The hospitals, however, fearing potential antitrust liability, joined with the local HSA and requested that the United States Department of Justice issue a review letter as to whether the proposed meeting would result in an antitrust violation. In addition, the Department of Health, Education, and Welfare asked the Department of Justice to encourage this type of ''concerted activity'' among the local HSAs, principally for the cost containment reasons espoused in the Act. The Department of Justice, however, did not issue a business review letter, which can be interpreted as indicating that they cannot, at present, sanction the ''concerted activity'' proposed to be undertaken by the local HSA and the hospitals involved.

Conclusion

While it is clear that a literal, rigid reading of the antitrust laws would create a sizeable obstacle to the achievement of the purposes and goals of the Act and the other health care laws, it is not so clear exactly how the differences between these laws will be reconciled. Whether it will be through the use of the ''state action'' or the ''implied repeal'' doctrines, or through the use of some other means, it appears, at least at present, that the courts are willing to subordinate the antitrust laws in order to permit the ''concerted activity'' required under the health care laws.

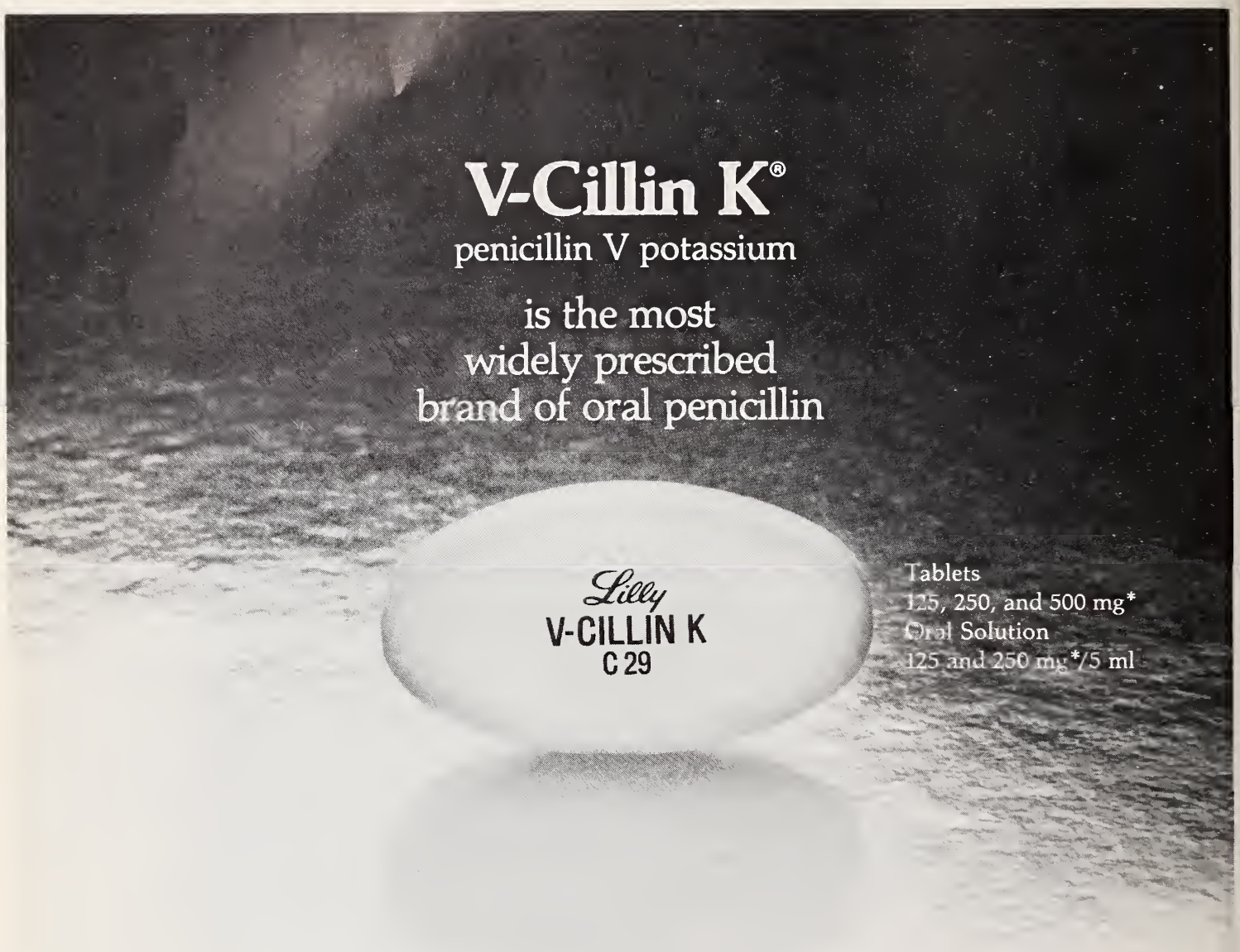
Notes

1. Public Law 93-641, 42 U.S.C. §§300k, *et seq.*

2. See, e.g., *Addyston Pipe & Steel Co. vs. U.S.*, 175 U.S. 211 (1899); *U.S. vs. Topco Associates, Inc.*, 405 U.S. 596 (1972). The significance of the application of the *per se* illegality test, as opposed to a ''rule of reason'' test, is that the existence of the collective activity, in and of itself, would be unlawful; and it would be irrelevant that the collective activity was undertaken for a laudatory purpose, such as to limit excess facilities or to contain costs, or achieve a beneficial result, such as eliminating duplicity of services or facilities.

3. 1979 Trade Cas. ¶62,520 (E.D. Mich., March 2, 1979).

4. No. 78-0359-CV-¶-3 (W.D. Mo., November 2, 1979).



V-Cillin K®
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

900416

heart page
heart page
heart page

Vasodilator Therapy of Chronic Congestive Heart Failure

C. DANIEL CABANISS, M.D., *Columbus**

Introduction

RECENTLY, much attention has been directed to manipulating the major determinants of ventricular function in an attempt to improve the status of the failing heart. These determinants are: the state of myocardial contractility, heart rate, pre-load (diastolic ventricular volume), and afterload (impedance to ventricular emptying).

The time-honored use of diuretics to reduce intravascular volume and the use of digitalis to enhance contractility suffice in many cases, but in more severe forms of ventricular dysfunction, they are inadequate.

Potent therapeutic agents are now available for the reduction of pre-load and afterload through production of venous dilatation of the capacitance vessels and arteriolar dilatation of the resistance vessels, respectively. Our knowledge of the hemodynamic effect of these agents has been furthered by the widespread use of Swan-Ganz catheters to measure pulmonary capillary pressure and thermodilution cardiac outputs.

The use of these therapeutic agents is indicated predominately in three areas: (1) acute myocardial infarction with severe congestive heart failure, cardiogenic shock, or hypertension; (2) acute cardiac overload due to acute mitral or aortic regurgitation, acute ventricular septal defect, or hypertensive crisis; and (3) chronic congestive heart failure due to myocardial disease.

It is the latter group, chronic congestive heart failure, that this article will consider primarily.

Therapeutic Treatment of Chronic Congestive Heart Failure

Hemodynamic measurements in the patient with chronic congestive heart failure due to myocardial disease usually reveal a combination of increased left ventricular filling pressure and reduced cardiac output. These findings correlate clinically with symptoms of pulmonary congestion (increased left ventricular filling pressure) and fatigue and weakness (reduced cardiac output). Available therapeutic agents for ambulatory use with their predominant sites of action are listed in Table 1.

As shown in Table 1, it would appear that prazosin is the drug of choice due to its balanced effect on venous and arterial tone. Unfortunately, however, there appears to be tachyphylaxis with chronic usage and the subsequent return of acutely improved values to pre-treatment levels. The most efficacious drug regimen to date

Dr. Cabaniss is Director of Medical Education, The Medical Center, P.O. Box 951, Columbus, GA 31902.

Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

TABLE 1 — Therapeutic Agents for Ambulatory Use With Congestive Heart Failure

	Venous Tone	Arterial Tone	Cardiac Output
(1) Nitrates (oral, sublingual, chewable, topical)	+++	+	+
(2) Prazosin	++	++	++
(3) Hydralazine	—	+++	+++

appears to be a combination of oral, sublingual, and/or topical nitrates with hydralazine.

Of the long-acting nitrates, isosorbide dinitrate (in oral, sublingual, or chewable forms) has been studied most extensively. The drug must be administered on a 3-4 hourly basis during waking hours. To achieve a safe, maximal pre-load reduction in the ambulatory patient, dosage should begin at a low level and increased gradually to achieve maximum improvement of symptoms in pulmonary congestion or side effects of intractable headache or postural hypotension. Carefully titrated topical nitroglycerin ointment may be used at bedtime to prolong the effect during the night. Refer to the articles listed in the bibliography for specific dosage and precautions.

The smooth muscle arteriolar dilator hydralazine has been proven to effectively reduce afterload and increase cardiac output. Fortunately, the tachycardia produced by this drug in the non-failing heart seems to be attenuated in chronic myocardial failure and is not usually a problem.

Again, dosage should begin at a low level and be gradually pushed to maximum tolerable levels or a maximum of 200-300 mgm. daily in four divided doses. At maximal levels, side effects, especially the "lupus-like" syndrome, must be kept in mind. Hypotension of a significant degree usually does not occur, but if it is excessive, it may require dose reduction or discontinuance.

There is evidence that minoxidil when available for general use may have a similar action.

There is little or no evidence as to whether these agents improve survival. In selected patients, however, they may improve symptoms markedly when conventional therapy has failed, and they should be considered for the patient with chronic intractable failure due to myocardial disease.

Bibliography

Cohn JN, Franciosa JA: Vasodilator therapy of cardiac failure. N Engl J Med 1977; 297:27, 254.

Chattenjee K, et al.: Combination vasodilator therapy for severe chronic congestive heart failure. Ann Int Med 1976; 85:467.

Hardarson T, Henning H, O'Rourke R: Prolonged salutary effects of isosorbide dinitrate and nitroglycerin ointment on regional left ventricular function. Am J Cardiol 1977; 40:90.

Zelis R, et al.: How much can we expect from vasodilator therapy in congestive heart failure? Circulation 1979; 59:1092.

NEW
PRODUCT
INFORMATION

clinical significance



of constipation

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Constipation acute or chronic

Constipation may be caused by conditions affecting the filling and emptying of the rectum.

Inadequate filling

Interference in propulsive contractions

Impairment of smooth muscle contractility

Obstruction of the lumen





Inadequate emptying

Interference in the stimulation of the defecation reflex

An additional complication

Self treatment—use and abuse of laxatives

Treatment of underlying disorders is critical...
Relief of constipation is essential

Perdiem™...distinctive!

A unique blend of natural vegetable derivatives For comfortable and safe relief of constipation

Psyllium

- A natural source of hydrophillic colloids
- Strengthens stimulus to defecate by increasing indigestible residue
- Helps produce soft, hydrated, well formed stool



Senna

- Produces mild peristaltic stimulation
- Helps propel bulk through colon



A unique granular formulation

- No mixing or chewing
- Granules are placed in mouth and swallowed with full glass of beverage
- Helps break cathartic habituation
- Helps establish normal defecatory reflexes and regular bowel rhythm

John Maerz, M.D.
Medical Director
W. H. Rorer, Inc.
Fort Washington, PA 19034

Dear Dr. Maerz:

Yes, I would like to receive a supply of Perdiem™ starter samples for my patients.

Dr. _____

Address _____

City _____

State _____

Zip _____

Specialty _____

SJ-312

New Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydracollaid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours): reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiavascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules; 100 gram (3.5 oz.) and 250 gram (8.8 oz.) canisters.



Made in West Germany

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 29 Ft. Washington, PA.

POSTAGE WILL BE PAID BY ADDRESSEE

William H. Rorer, Inc.
500 Virginia Drive
Ft. Washington, PA. 19034

Attn: Marketing Services

ROER

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Current Management of Nonseminomatous Testis Tumors

THOMAS W. SCHOBORG, M.D., A. P. RODRIGUEZ, M.D., and CHARLES SCOTT JR., M.D., *Atlanta**

TESTICULAR TUMORS can be pathologically classified, in order of frequency, as seminomas, embryonal cell carcinomas, teratocarcinomas, and choriocarcinomas. Seminomas have traditionally been treated with radiotherapy with uniformly good results, and survival rates in seminomatous tumors over the years have not changed significantly. However, recent advances in the treatment of nonseminomatous testis tumors in the last 30 to 40 years have resulted in one of the greatest "success stories" in urologic oncology. Overall survival rates have risen from 30% to 40% at the time of World War II to nearly 80% today. Significantly contributing to this dramatic improvement in survival have been more thorough and complete retroperitoneal lymph node dissection and more effective chemotherapeutic agents. Still lacking, however, is a public awareness of this disease such as has developed with regard to breast cancer.

Although the testis is one of the less common sites of cancer, it was estimated that there would be about 4,000 new cases (including seminomas) in the United States in 1979.[1] On the basis of the Third National Cancer Survey data, about one in 333 newborn white males might be expected to experience cancer of the testis during his lifetime, and one in 1,000 newborn nonwhite males.[2] The SEER Program information on cancer of the testis shows the highest incidence rates in the 25- to 34-year age group.[3] In 1976, there were 727 deaths from cancer of the testis, and the estimated number for 1979 was 750.[4]

Diagnosis and Staging

A painless, palpable mass is the most common physical finding on examination, and it is usually found incidentally. The most common misdiagnosis is chronic epididymitis, and this often causes a significant delay in diagnosis. The diagnosis should be established by a high inguinal radical orchiectomy. Further work-up should include a chest x-ray with tomograms to rule out lung metastases, intravenous pyelography to assess any ureteral displacement by enlarged lymph nodes, a liver scan when liver enzymes are elevated, and the serum tumor markers alpha-fetoprotein and beta human chorionic gonadotropin to evaluate further evidence of metastatic disease. Tumor markers have assumed a prominent role in diagnosing a persistent tumor after orchiectomy, since no false positives have been reported. A

* Drs. Schoborg, Rodriguez, and Scott are from the Department of Urology, Georgia Baptist Medical Center and Piedmont Hospital in Atlanta. Direct reprint requests to Atlanta Urological Group, 340 Boulevard, Ste. 11, Atlanta, GA 30312.

Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

significant number of false negatives have been reported, however, thus making total dependence on serum markers to stage testis tumors unreliable.[5]

Similarly, because of the high incidence of false-negative results, lymphangiography is regarded as inaccurate in assessing retroperitoneal lymphatic spread.[6] At present, lymphangiography finds its greatest usage in staging seminomatous tumors for later radiation therapy, since lymphadenectomy remains the most accurate method of staging non-seminomatous testis tumors. Computerized tomography is helpful in assessing the extent of massive retroperitoneal disease but is not helpful in diagnosing microscopic spread. Scalene node biopsy has yet to find a useful role in staging. Bone and brain scans are most valuable in assessing the patient with clinical evidence of massive disease.[7]

Having completed the aforementioned diagnostic procedures, staging can be assessed as follows: stage A, disease confined to the scrotum with negative nodes and no other evidence of disease; stage B1, metastases to fewer than six retroperitoneal nodes with no node greater than 2 cm. in diameter; stage B2, metastases to six or more retroperitoneal lymph nodes or any metastasis greater than 2 cm. in diameter; stage B3, bulky abdominal disease detected grossly on abdominal examination before surgery, usually associated with significant ureteral deviation and/or obstruction; stage C, metastases above the diaphragm or to viscera (liver).

Treatment

After high inguinal radical orchiectomy has established the primary diagnosis, further initial therapy should include a thorough retroperitoneal lymph node dissection to include all lymph bearing tissue above the ipsilateral renal pedicle superiorly, up to and including the ipsilateral ureter and contralateral great vessel laterally, and down to the bifurcation of the iliac arteries inferiorly.[7] Since a significant number of lymph nodes are situated between the great vessels and the anterior spinal ligaments,[8] the dissection should include ligature of lumbar vessels inferior to the renal arteries to insure complete lymphatic removal. Ligation of lumbar vessels above the renal arteries is unnecessary and may result in paraplegia. The surgical approach may be either transabdominal through a midline incision as



Figure 1 — Left thoraco-abdominal retroperitoneal lymphadenectomy on a 24-year-old white male with embryonal carcinoma of left testis. More than six nodes in the pathologic specimen were involved, making this a case of stage B2 disease. Suprahilar dissection up to celiac axis, including left adrenal, was performed. Right lateral limit of dissection was to the lateral vena cava, excluding the right sympathetic chain.

advocated by Donohue and associates,[8] or modified thoraco-abdominal as advocated by Skinner.[7] The latter approach seems preferable, since better exposure of the suprahilar ipsilateral renal pedicle is afforded, and a complete dissection can be performed retroperitoneally, thus eliminating significant post-operative morbidity in the form of adynamic ileus. The contralateral sympathetic chain may be spared, thus preserving ejaculatory capabilities in some patients (Figure 1).

Adjuvant radiotherapy is regarded as unhelpful and may actually hinder full usage of future chemotherapy. Adjuvant chemotherapy is of utmost importance in overall management of testis tumors. Various protocols have been utilized, with the most successful incorporating actinomycin D, vinblastine, bleomycin, and cis-platinum. A reasonable and highly therapeutic regimen is that proposed by Skinner and associates[5] as described in Tables 1 and 2. With strict adherence to these protocols, tumor-free survivals of 100% for stage A disease, 91% for stage B disease, and 61% for stage C disease have been obtained.

Obviously, tremendous achievements have been made in the management of nonseminomatous testis tumors. Many improvements are still necessary, however, and should include (1) more accurate tumor markers to better stage testis tumors and possible obviate the unnecessary lymphadenectomies as performed in stage A disease and (2) more specific and effective chemotherapeutic agents. Greater public awareness of this disease is extremely important, and programs encouraging self examination, such as those already developed in screening for breast cancer, should be instituted.

Table 1 — Management of Clinical Stage A and B Nonseminomatous Germinal Tumors of the Testis, January 1974 to 1979.[5]

Initial Therapy	Pathologic Stage	Adjuvant Therapy
Lymphadenectomy (Actino D, 1 mg. intraoperative, 0.5 mg. postop Day 1 & 3; 1 mg. postop Day 2 & 4)	A (Negative nodes and markers)	One course Actino D (4 mg. over 5 days) 2 mos postop
	B1 (Microscopic metastasis to < 6 nodes negative markers)	Actino D (4 mg. over 5 days) q 2 mos × 6 then q 3 mos × 4
	B2 (metastasis to 6 or more nodes or any node 2 cm., extracapsular spread or positive markers)	V-B*, then Actino D × 24 mos as for Stage B1

* V-B Bleomycin 30 units, IM twice a week × 5 weeks (300 units total). Vinblastine sulfate 10 mg IV Day 1. 15 mg IV Day 8, and 20 mg IV Day 22 (30 mg Prednisone given p.o. with each injection vinblastine sulfate).

Table 2 — Current Management Protocol for Clinical Stage B3 or C Nonseminomatous Germinal Tumors of the Testis[5]

Initial Therapy						
Platinum* Vinblastine sulfate q 3 wks × 3 — 2 WK Bleomycin	No Response→Continue		P* V ± VP-16‡ B			
	Response→	Cytoreductive→ Surgery	Embryonal Ca	Present	P* V q 3 wks × 3 B	Maintenance →Actino D q 2 mos × 3 then 3 mos × 4
				Absent	V† × 5 wks B	

* Platinum 20 mg/m² IV q.d. × 5; repeated q 3 weeks × 2 (total 3 courses). Bleomycin 30 units IV a week × 12. Vinblastine sulfate 0.2 mg/Kg IV days 1 & 2 of Platinum infusion.

† Bleomycin 30 units IM twice weekly × 5 weeks (300 units total). Vinblastine sulfate 10 mg IV day 1, 15 mg IV day 8, 20 mg IV day 22 (30 mg prednisone given orally with each Vinblastine injection).

‡ VP-16 4′-Demethyl-epipodophyllotoxin-B-D-ethylidene glucoside.

References

1. Silverberg E: Cancer statistics — 1979. Ca 1979;29:6-21.
2. Seidman H, Silverberg E, Bodden A: Probabilities of eventually developing and of dying of cancer. Ca 1978; 28:33-46.
3. Biometry Branch, National Cancer Institute: SEER Program, unpublished data.
4. U.S. Public Health Service, National Vital Statistics Division: Vital Statistics of the United States, Annual, 1930-1976. Washington, U.S. Government Printing Office, 1934-1978.
5. Skinner DG, Scardino PT: Relevance of biochemical tumor markers and lymphadenectomy in management of nonseminomatous testis tumors: current prospective. Surg 1979; 86:86.
6. Safer ML, Green JP, Crews QE, Hill DR: Lymphangiographic accuracy in the staging of testicular tumors. Ca 1975; 35:1603.
7. Skinner DG, Dekernion RB: *Genitourinary Cancer*. Philadelphia, PA: WB Saunders 1978, p. 453-478.
8. Kaswick J, Bloomberg S, Skinner DG: Retroperitoneal lymph node dissection: how effective in removal of all retroperitoneal nodes? J Urol 1976; 115:70.
9. Donohue JP: Retroperitoneal lymphadenectomy: the anterior approach including bilateral suprarenal-hilar dissection. In, *The Urologic Clinics of North America*. Philadelphia, PA: WB Saunders 1977, p. 509.

DECATUR NORTH PROFESSIONAL BUILDING



- ADJACENT TO DECATUR HOSPITAL IN HEART OF DECATUR
- WITHIN TWO MILES OF DeKALB GENERAL VETERANS ADMINISTRATION AND EMORY UNIVERSITY HOSPITALS
- TWO BLOCKS FROM DECATUR MARTA RAPID TRANSIT STATION
- NINE STORIES WITH 87,000 SQUARE FEET
- ON-SITE OWNER MANAGEMENT
- COVERED PARKING FOR TENANTS
- TWO HOURS' FREE PARKING FOR PATIENTS
- ON-PREMISES PHARMACY, RADIOLOGICAL DEPARTMENT, LABORATORY, MEDICAL SUPPLIES, OPTICAL SHOP, BARBER SHOP AND SANDWICH SHOP

The Decatur North Professional Building, specializing in space for professional practices, is located in the Heart of Decatur and close to four major hospitals. Within easy access to bus and rail transportation, Decatur North Professional Building is quickly accessible to Atlanta and other points in metropolitan Atlanta.

EQUITABLE

CALL:
MARTIN D. TAFFEL, PROPERTY MANAGER
Decatur North Professional Building
755 Columbia Drive, Decatur, Georgia 30030
Leasing Information 404/377-9984 or 586-1165

NEW MEMBERS

Alvarado, Romulo R., South Georgia—ACT—PD
Oak Center 11, Bldg. J, Valdosta 31601

Carmichael, Grant P., Crawford W. Long—ACT—FP
700 Oglethorpe Ave., Athens 30606

Cox, Raymond L., Jr., MAA—ACT—OBG
401 W. Peachtree St. NW, Ste. 1670, Atlanta 30308

del Mazo, Jacinto, MAA—ACT—IM/GE
950 W. Peachtree St. NW, Atlanta 30309

Elder, John F., Crawford W. Long—ACT—OBG
740 Prince Ave., Athens 30601

Fincher, Ruth-Marie E., St. John's Parish—N2—IM
P.O. Box 37, Ludowici 31316

Firth, Paul G., Bibb—A—OBG
Box 129, Macon 31208

Goldstein, Dorian L., Bibb—A—OBG
Box 6000, Macon 31208

Gottlieb, George R., DeKalb—N2—AN
365 Winn Way, Decatur 30030

Gregory, J. Michael, Crawford W. Long—ACT—U
1010 Prince Ave., Athens 30601

Harrison, William V., Camden-Charlton—ACT—GP
100 Passieu Cir., Folkston 31537

Hemmer, John L., Jr., Hall—N2—ORS
710 Broad St., Gainesville 30501

Hosford, James M., Hall—N1—PD
1220 Sherwood Park Dr., Gainesville 30501

Jones, Mack D., Dougherty—ACT—N
806-14th Ave., Albany 31701

Kessler, Michael B., Cobb—ACT—EM
1230 Johnson Ferry Rd., Marietta 30067

Magill, Daniel H., Crawford W. Long—N2—CD
700 Oglethorpe Ave., Athens 30606

McDonald, Allen P., MAA—ACT—ORS
229 Peachtree St. SE, Ste. 200, Atlanta 30303

Miles, Robert L., Crawford W. Long—ACT—R
Athens General Hospital, Athens 30606

Miller, James S., Crawford W. Long—N2—IM
700 Oglethorpe Ave., Athens 30601

Newland, Hillary R., Crawford W. Long—ACT—PTH
Athens General Hospital, Athens 30606

Parker, Wiley A., MAA—N2—OTO
5669 Peachtree-Dunwoody Rd., Ste. 295, Atlanta 30342

Parrott, Frank H., Dougherty—N2—IM/PUD
806 14th Ave., Albany 31701

Rahn, Charles L., Bibb—A—FP
784 Spring St., Macon 31201

Ritchie, Patricia, MAA—N2—EM
2430 Melinda Ct., Atlanta 30345

Roseberry, Everett H., Hall—N2—PD
650 Broad St., Gainesville 30501

Rosenfeld, Joseph M., DeKalb—ACT—PD
5040 Snapfinger Woods Dr., Decatur 30032

Safra, Mark J., DeKalb—N2—OPH
1276 McConnell Dr., Decatur 30033

Segerberg, Eric C., Glynn—N2—GS
3215 Shrine Rd., Brunswick 31520

Silver, Jerome I., Hall—N2—R
675 White Sulphur Rd., Gainesville 30501

Underwood, Damon J., Bibb—A—FP
784 Spring St., Macon 31208

Whigham, Charles H., Camden-Charlton—N2—GP
P.O. Box 668, Woodbine 31569

PERSONALS

Second District

The Brooks County Hospital Authority honored the county's doctors with an appreciation dinner on December 7. Those MAG members honored are **Robert Cain, M.D., Norris Lewis, M.D., Walter Romine, M.D.,** and **L. M. Shealy Sr., M.D.,** all of Quitman.

Fifth District

Michael A. Chorches, M.D., of Atlanta was named a Fellow in the American College of Chest Physicians at the society's ceremonies held November 7 at the Hyatt Regency Hotel in Houston, Texas.

Alexander S. Haraszti, M.D., and his wife, **Rosalie Haraszti, M.D.,** have recently opened practices at Henry General Professional Building.

Mahir Tekin, M.D., an anesthesiologist at Henry General Hospital, has recently opened a pain clinic in the nearby doctor's professional building.

The American College of Chest Physicians has named **Kenneth E. Thomas, M.D.,** Atlanta, as a Fellow in their

The Department of
Obstetrics and Gynecology
at the Georgia Baptist Medical Center
and the Atlanta Fertility Institute

announce

Post Graduate Symposium
Reproductive Tract
Reconstructive Surgery

April 11 & 12, 1980, Atlanta, Georgia

This symposium is focused on corrective procedures of female reproductive tract organs covering topics such as: Vaginal agenesis, uterine malformation, uterine myoma, pelvic endometriosis, pelvic relaxation, fistula and tuboplasty (fimbrioplasty, end to end anastomosis, and reimplantation).

Speakers include: Tommy Evans, M.D., John C. Weed, M.D., Veasey Buttram, M.D., Maxwell Roland, M.D., Joseph Stern, M.D., Amir H. Ansari, M.D., Cullen Richardson, M.D., Nabil Elsahy, M.D., John Carter, M.D., and M. Arshad, M.D.

Approved: 12 Cognates and 12 Category I AMA Credits.

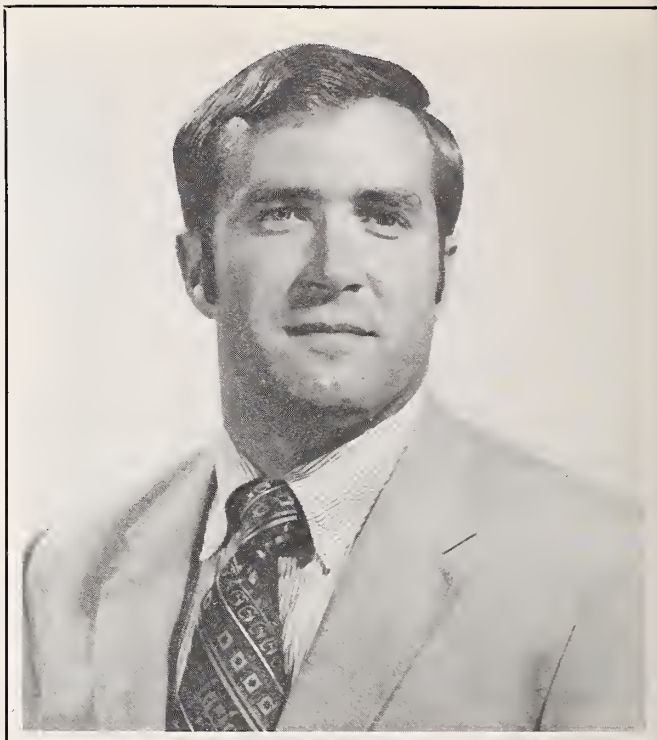
For further information contact: Amir H. Ansari, M.D., 340 Boulevard, Suite 641, Atlanta, Georgia 30312, (404) 659-5211.

APPLICATIONS ACCEPTED FOR MINI-FELLOWSHIPS IN EPILEPSY AND RELATED NEUROLOGICAL DISORDERS

The Georgia Comprehensive Epilepsy Program (CEP) is offering a 3 to 5 day mini-fellowship in epilepsy and related neurologic disorders. Participants will attend clinics, ward rounds, and conferences conducted by the Neurology Department at the Medical College of Georgia (MCG). The time will include participation in electronic monitoring of seizure activity in the Diagnostic and Treatment Unit for Epilepsy (DTU). Travel to and from Augusta and living expenses will be paid by the CEP. In special cases, an additional small stipend will be awarded. Preference will be given to physicians in private practice of family medicine or pediatrics. Dates for the fellowship will be arranged between Dr. Joseph Green and the applicant.

Those interested should contact: Joseph B. Green, M.D., or Thomas Casaday, Department of Neurology, MCG, Augusta, GA 30912. PH: (404) 828-4581.

MCG is an Equal Opportunity Educational Institution



Congratulations are in order for RUSTY KIDD who was recently promoted to the newly-created position of Associate Executive Director of the MAG. Mr. Kidd will continue to direct MAG's legislative activities as he has done so capably for the past 7 years. In this new position, he will work closely with Executive Director James Moffett to better represent the interests of doctors in Georgia.

organization. Formal induction took place at convocation ceremonies held at the November 7 meeting in Houston.

Sixth District

Boonsong Anantalabhochai, M.D., has recently opened a urology practice in the Professional Building of the Henry General Hospital.

Seventh District

The Rome Chapter of the American Association of Medical Assistants recently named **J. Paul Ferguson, M.D.,** of Rome, as "Doctor of the Year" at their Christmas banquet.

Maury C. Newton Jr., M.D., Marietta, was recently elected a Fellow of the American College of Physicians.

William E. Holladay, M.D., Marietta, was named a Fellow in the American College of Chest Physicians on November 7 in Houston.

Drayton Sanders, M.D., Dalton, spoke at the November meeting of the Northwest Georgia Society of Radiologic Technology. He spoke on, "Diagnosis and Treatment of Pulmonary Emboli."

Gerald Stapleton, M.D., of Austell, was recently elected President-elect of the Greater Atlanta Otolaryngology Society.

Robert Wener, M.D., Marietta, has recently opened an ophthalmology clinic at Paulding Memorial Hospital.

Eighth District

Brunswick anesthesiologist, **Richard Nutt, M.D.,** was the guest speaker at the first meeting of the Brunswick Consumer Advocate Organization's Childbirth Division held in December.

Ninth District

Gainesville physician, **A. F. Bloodworth, M.D.,** was recently elected president of the Georgia Chapter of the American College of Chest Physicians.

Tenth District

Bashir A. Chaudhary, M.D., and **Gary N. Harrison, M.D.,** both of Augusta, have been named Fellows in the American College of Chest Physicians.

SOCIETIES

At their January meeting, the members of the **Cobb County Medical Society** heard George K. Schweitzer, Ph.D., a professor of chemistry at the University of Tennessee.

On December 17, the members of the **DeKalb Medical Society** heard the Honorable Elliott Levitas, Fourth District Representative to the U. S. Congress.

The **Medical Association of Atlanta** recently honored five Atlanta physicians who have practiced medicine for 50 years. Awards were given to Herbert S. Alden, M.D., Mason I. Lowance, M.D., Carter Smith Sr., M.D., E. Van Buren, M.D., and J. Harry Rogers, M.D. All are from Atlanta.

Mr. Roger Gardner, Social Security Representative of the Disability Section, spoke at the December meeting of the **Southwest Georgia Medical Society.**

At their December meeting, the members of the **Ware County Medical Society** saw a film entitled "Peripheral Vascular Disease — Treatment."

DEATHS

William Bruce Schaefer

William Bruce Schaefer, M.D., died on Nov. 1, 1979, at a Miami, Florida hospital.

Dr. Schaefer served as chairman of the Medical Association of Georgia and chairman of the board of Citizens Bank of Toccoa. He was past president of the Association of County Commissioners of Georgia.

Survivors include his wife, one daughter, and one son.

S. T. Ginsberg

S. T. Ginsberg, M.D., 73, died Dec. 3, 1979.

He was the superintendent of the Georgia Mental Health Institute and had been a clinic professor of psychiatry at Emory University since 1971.

Survivors include his wife, two daughters, a son, and two sisters.

1980 MAG Practice Management Workshops

in cooperation with Department of Practice Management, American Medical Association

STARTING YOUR PRACTICE

— workshop for residents —

March 12-13, 1980
Ramada Inn Central, Atlanta

This workshop is designed for young physicians planning to enter private practice and covers paperwork, patient management and public relations, personnel, physical characteristics of a medical office, "where and how," and legal problems.

Registration fee is $125 for members of a medical society; $95 for non-members. Spouses may audit at no charge (except $11 luncheon fee). Enrollment limited to first 25 registrants.

For further information and registration forms, Contact MAG's Division of Education, 876-7535 or (toll free) 800-282-0224

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

president's letter



Too Many Cooks Can Spoil the Broth

The other day Chef Executive Committee decided he would prepare a special broth for the Medical Association of Georgia (MAG). After much deliberation he decided on the exact recipe to use.

With glee, he set about his task — even working into the night. The broth was almost ready to serve when in walked his boss, Chief Chef Board of Directors. He tasted the broth and thought it was fair but said it needed *his* favorite ingredient, conservatism, so he added 1½ pounds. After tasting it, he decided there was too much conservatism, so he titrated 4 ounces of liberalism and added that to the broth over the objections of some of the minor cooks.

The broth tasted delicious. Then Super Chief Chef House of Delegates arrived. He tasted the broth, and said it needed 2 ounces of politics. After a long, often confusing debate and the addition of eight more condiments, the broth was ready for the MAG. When they tasted it, however, it made them sick, and they threw it all away.

Any of the chefs alone could have made a delectable broth. The secret is to work together and trust each other's recipe.

Sincerely,

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG



Tagamet®

brand of

cimetidine

How Supplied:

Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

SK&F LAB CO.
a SmithKline company

When painful spasm is the presenting symptom...



in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

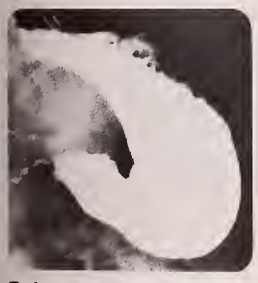
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INOICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISOROERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE ANO AOMINISTRATION: Oosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

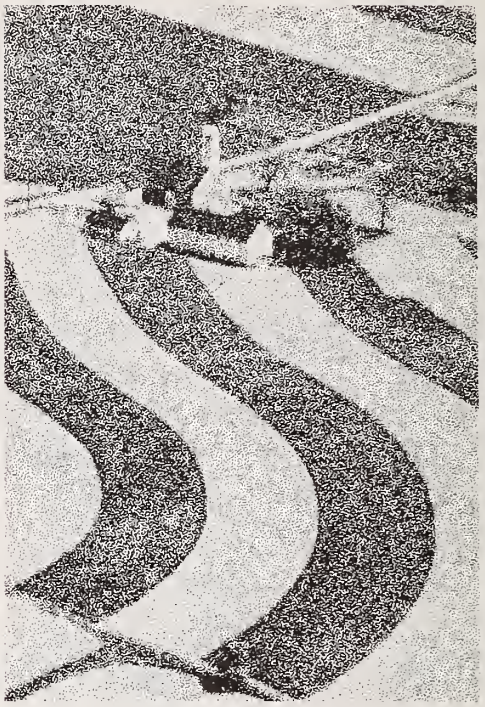
Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Oecatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A.

RURAL HEALTH CARE/ UPDATE 1980



American Medical Association 33rd National Conference on Rural Health Boston, Massachusetts April 17-18, 1980

Don't miss this outstanding opportunity to update yourself on the latest developments in the delivery of health care services in rural areas. Physicians can earn up to 15 hours of continuing medical education credit by choosing from over 30 workshops, CME courses, and general sessions.

Write today for complete information.

Dept. of Meeting Services
American Medical Association
535 N. Dearborn St.
Chicago, IL 60610

Please send me complete information on the *33rd National Conference on Rural Health, April 17-18, 1980.*

Name_____

Address_____

City_____

State/Zip_____

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



rivate, comprehensive mental health cen- designed and staffed to meet the indi- lual needs of patients by provision of a erapeutic milieu and the following special- d treatment programs:

DULT PSYCHIATRIC PROGRAM

lan that focuses on the particular require- nts of the patient is drawn up by his or her rsonal psychiatrist. It includes, in addition to milieu approach, group, recreational, horti- tural and occupational therapy.

HILD SERVICES

types of psychiatric and learning disorders treated with a multi-modality approach at this patient unit for children under 13 years of age. t-patient services and a day-care program an integral part of this service. All needed nooling is available.

DOLESCENT PSYCHIATRIC ROGRAM

ludes a state-accredited special education ddle and high school for patients ranging in e from 13 to 19 years. Patients participate in nilieu incorporating community identification, quent interaction with staff members and in- idual appointments with psychiatrists.

LCOHOL AND DRUG EHABILITATION PROGRAM

comprehensive, individualized program of de- ification and rehabilitation is offered the alco- l and drug patient. Each patient works with a therapeutic team in planning treatment, and em- phasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329
404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

A word to smokers and nonsmokers

(about freedom of choice)

You've seen the ads. The tobacco industry is spending millions saying freedom of choice means no limits on smoking.

But smoke drifts. So smokers often impose *their* choice on others around them.

And smoke is not just offensive. For many it is physically irritating or even harmful. That's why most nonsmokers find it annoying to be near a person smoking.*

But let's be clear—it's not the *smoker* we mind: it's the *smoke*. Smokers are welcome anywhere: their smoke is not.

Tobacco smoke can cause serious illness for millions with asthma, allergies or other conditions. Some have even had to be hospitalized.

So they can't eat in most restaurants, or work in many offices, or even go to the post office. Where is *their* freedom of choice?

To ensure true freedom of choice for everyone—not just for the 1/3 of adults who smoke—there should be no-smoking areas in all enclosed public places. Like hospitals, meeting rooms and restaurants.

Most nonsmokers *and smokers* favor no-smoking areas.** And where they've been tried, they've generally worked well.

Given a choice (as on airlines) most people choose air unpolluted by tobacco smoke.

No-smoking sections give us *all* a choice. Without them, smokers impose their choice on everyone else.

Which do you prefer?

*In a U.S. Public Health Service survey, 77% of the nonsmokers and 35% of the smokers agreed, "It is annoying to be near a person smoking cigarettes."—Adult Use of Tobacco, 1975.

**In the survey cited above, 82% of the nonsmokers and *51% of the smokers* agreed, "Smoking should be allowed in fewer places than it is now." And in a 1977 Gallup Poll, 68% of all adults (including *70% of the smokers*) favored special areas for smokers in public places, while an additional 16% would ban all smoking in public places.



Action on Smoking and Health (ASH)
2000 H Street, N.W.
Washington, D.C. 20006

For more information, write ASH. To help pay for this ad and to help us fight for nonsmokers' rights, please send a tax-deductible check payable to ASH-AD.

The Great CHEROKEE TRADING COMPANY®

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

TEGA-CODE TABLETS C-111

ANALGESIC - ANTIPYRETIC - SEDATIVE

Each tablet contains:

Acetaminophen	300 mg.
Salicylamide	200 mg.
*Sodium Pentobarbital (derivative of barbituric acid)	10 mg.
*Codeine Phosphate	(½gr.) 32.4 mg.

***WARNING: May be habit forming.**

Action: Combination of analgesic and antipyretic with sedative.
Indications: Indicated in cases of severe pains, especially when associated with tension, pains and discomforts of neuralgia, rheumatism and arthritis.
Precaution: Use with caution in persons with known allergies to salicylates and barbiturates and in those with active peptic ulcer.
Warning: Long administration may cause habituation.
Side Effects: Large doses may cause nausea, vomiting, skin rash and sometimes anaphylactic reactions.
Contraindications: Idiosyncrasy to any component.
Supplied: Available in bottles of 100 and 1000.
Dose: Adults, one tablet 3-4 times daily, as directed by a physician.

CAUTION: Federal Law prohibits dispensing without prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

DECATUR HEARING AID SERVICE

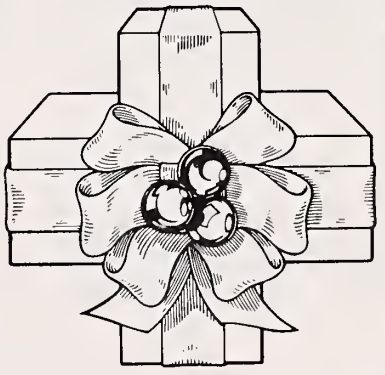
Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



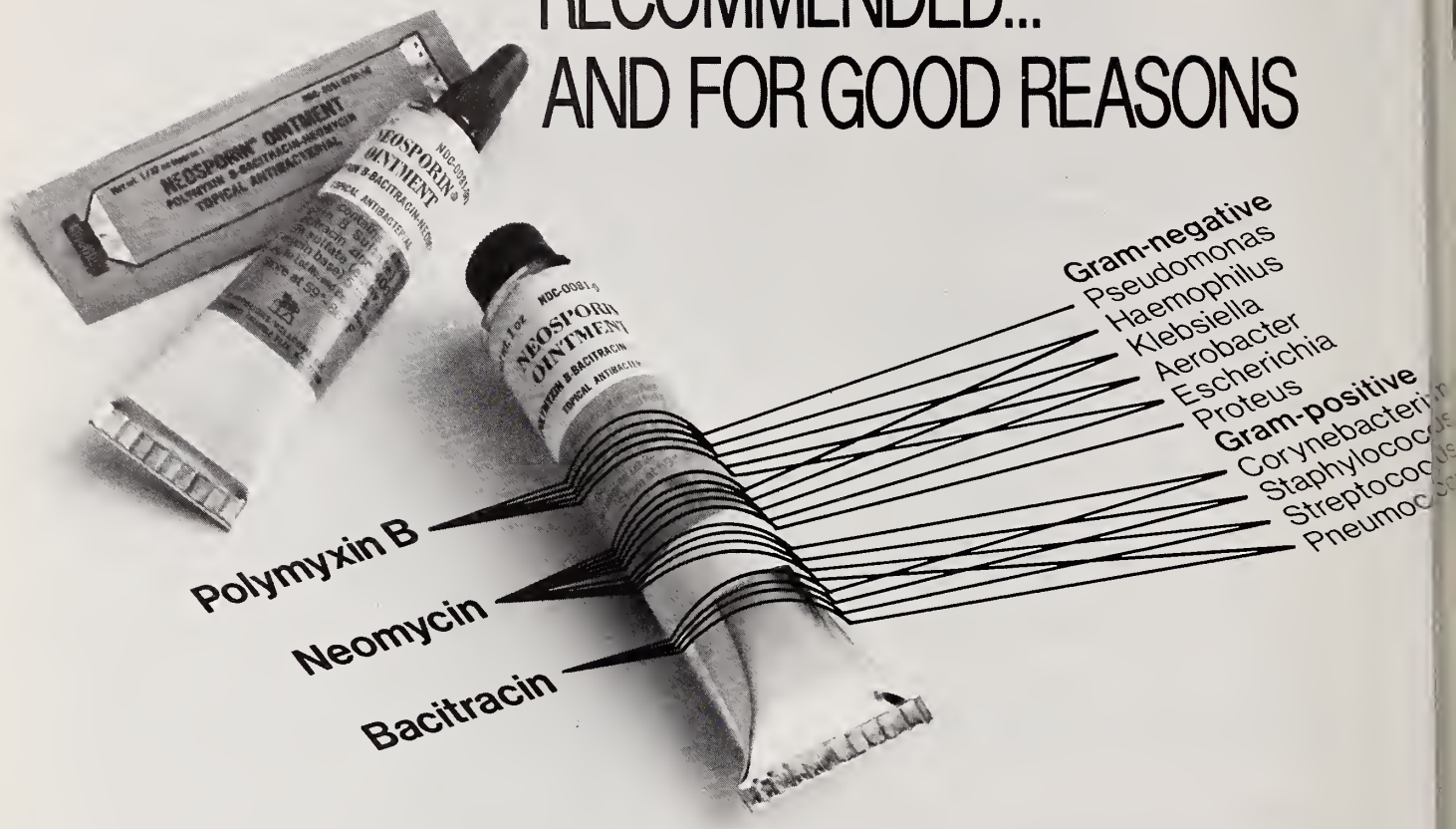
R.H. BAKER
21 Years' Service

GIVE SOMEONE A GIFT THEY CAN'T LIVE WITHOUT.

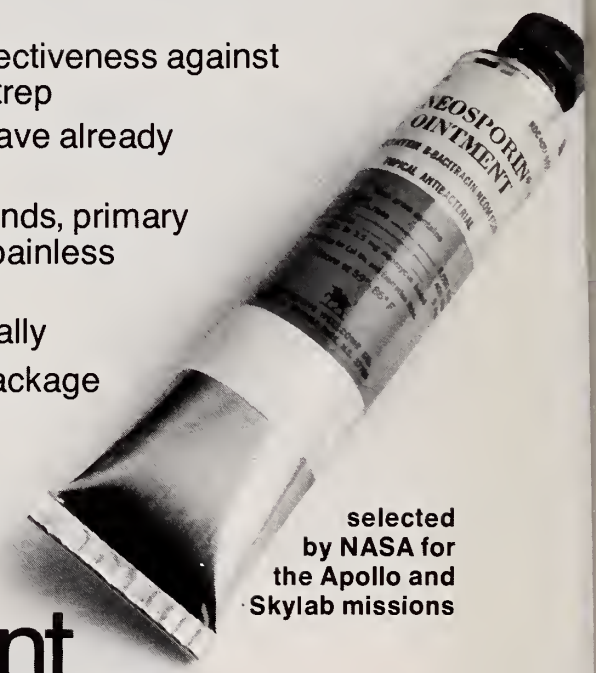


American Red Cross

IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
2. helps prevent topical infections, and treats those that have already started
3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically
5. you can recommend it in any of the three convenient package sizes: 1 oz tube, ½ oz tube, or the versatile, single-use foil packet



selected by NASA for the Apollo and Skylab missions

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$10.00 for the first 50 words; $.15 per word for each additional word. **Non-members**—$20.00 for the first 50 words; $.20 per word for each additional word. *Charges are payable in advance.* Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535, INWATS in Georgia (800) 282-0224.

PHYSICIANS WANTED

PSYCHIATRIST WANTED for busy private general psychiatric practice. In-patient and out-patient — new psychiatric unit opened. Macon, Georgia. POSITION AVAILABLE IMMEDIATELY! Reply Box 2-A, c/o the *Journal,* 938 Peachtree St., NE, Atlanta, GA 30309.

NEED FAMILY PRACTICE, PEDIATRIC, AND INTERNAL MEDICINE doctors to staff a three doctor and one dentist (committed) medical clinic. Clinic to be built by individuals in Hokes Bluff, Alabama. Completion date July 1980. Residential community 3,500 population, 15,000 in trade area, adjoining Gadsden, Alabama — population of 60,000. Two modern hospitals (600 beds). Both have 24-hour emergency room coverage. Over 1,400 in local schools — 3A sports. Jr. College and 4-year college nearby. This is not poverty area and doesn't qualify for government grants, etc. Less than 5% Medicaid patients. Workers have good income, mostly from Gadsden industries. Area is highly insurance oriented on both prescription drugs and medical services. No doctors here at present, but one left due to overwork. Contact: Scott Godfrey, R.Ph. or Bill Street, R.Ph., Rt. 7, Box 459, Gadsden, AL 35903, (205) 492-3521 or 492-4238 (Street residence).

FOR SALE, RENT, OR LEASE

OFFICE SPACE, CENTRAL COBB COUNTY. 1,246 sq. ft., 3 exam rooms, lab, business office, waiting room, doctor's office, 2½ baths, $525/mo. For sale — 3,800 sq. ft., 3-suite professional building. Good terms, $140,000. Also Roswell Rd., N. Fulton County. Owner will build to suit. N. Fulton Realty, 2163 Northlake Parkway, Tucker, GA. Gene Wise 939-9451.

ATTENTION MEDICAL AND DENTAL SPECIALISTS — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call 634-1234.

WEST MARIETTA PROFESSIONAL BLDG., Powder Springs Rd. Medical and dental suites available. Rent with option to buy. Call AFTCO Associates, (404) 992-5632.

FAST-GROWING AREA IN METRO ATLANTA needs family practitioner. Will build to specifications the building of your desire. Will rent, lease, or sell at lowest price possible. Call 922-8122 for details.

SITUATIONS WANTED

THIRTY-YEAR OLD AMERICAN INTERNIST, university trained, ABIM certified, desires group practice, general internal medicine, in Atlanta area. Call 953-0061.

SERVICES

THE SKY'S THE LIMIT. Would you like to learn to fly? Escape to new horizons? Many of our colleagues are pilots — why not be one too? I am a Certified Flight Instructor. Call me and let's talk flying. William J. Morton, M.D., 3646 Chamblee-Tucker Rd., Atlanta, GA 30341 (404) 939-8031.

ART

NEIMAN, DALI, ROCKWELL, DELACRIOX, BOULANGER, HIBEL, VASARELY, CHAGALL, FRIEDLANDER, MOORE, and many others. Great savings. Investment programs for appreciation and tax savings. Art for pension plans. Appraisals. Locator service. We ship anywhere. Have art you want to sell? Call us, we will buy or broker.

ART INVESTMENT (404) 255-7549.

Index to Advertising

Vol. 69 FEBRUARY 1980 No. 2

Action on Smoking and Health 150
AFS International Exchanges 89
American Medical Association 148
American Red Cross 151
Ballard, Walter, Optical Company 150
Boehringer Ingelheim Ltd. 86, 87, 88
Brawner Psychiatric Institute 76
Burroughs Wellcome Company 152
Classifieds 153
The Coca-Cola Company 158
Decatur Hearing Aid Service 151
Decatur North Professional Building 140
The Devereux Foundation 157
Dickey-Mangham Company 143
Fulton Federal Savings and Loan Association 84
Georgia Baptist Medical Center 142
Georgia National Guard 116
Georgia Society of Certified Public Accountants 75
Global Imports 124
The Great Cherokee Trading Company 150
Lilly, Eli, and Company 130
MAG Practice Management Workshop 143
The Medical Arts Motel 84
Medical Buildings and Equipment, Inc. 83
Medical College of Georgia 142
Medicard 79
Merrell-National, Inc. 84, 85, 146-148
The Morrill House 81
Office Communications, Inc. 82
Ortega Pharmaceutical Company, Inc. 151
Peachtree and Parkwood Mental Health Center and Hospitals 149
Potter-Holden and Company 120
Psychiatric Institute of Atlanta 120
Roche Laboratories 74, 155, 156
Rorer, William H., Inc. 133-136
Smith, Kline, & French 145
United States Savings Bonds 126
Valley Psychiatric Hospital 83
Weight Watchers of Greater Atlanta 120
Willingway Hospital 101
Wyeth Laboratories 105-108

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

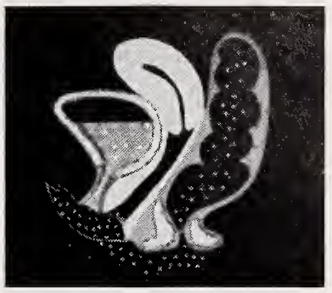
ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets



Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

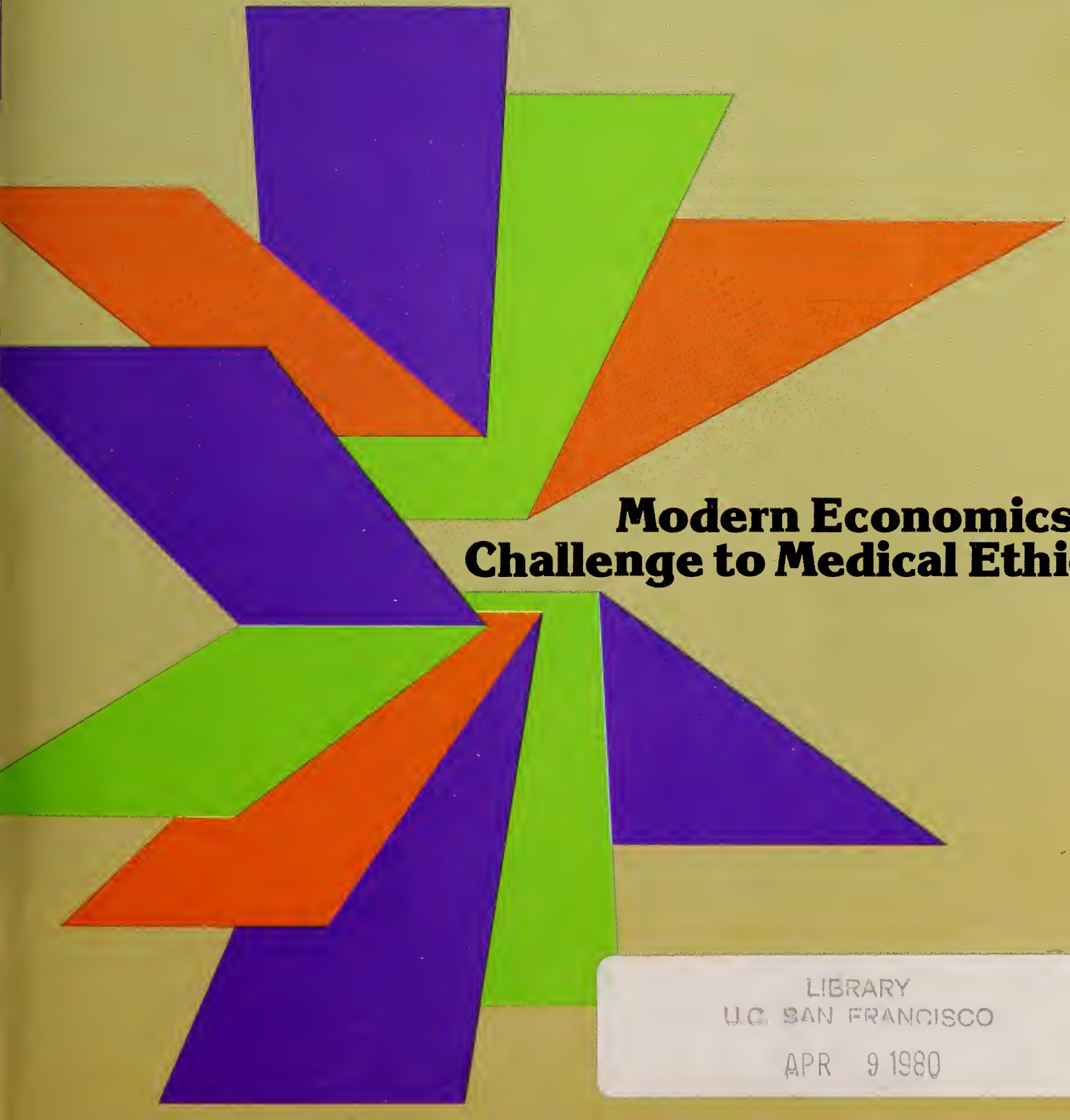
The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of intro colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal trac

Please see reverse side for summary of product information.

JOURNAL
of the medical association of
georgia
ISSN·0025·7028 MARCH / 1980



Modern Economics' Challenge to Medical Ethics

LIBRARY
U.C. SAN FRANCISCO
APR 9 1980



proven antianxiety

Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). **And today this promise continues to be fulfilled in a wide variety of patients you see every day.**

ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® (IV)

chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- An unsurpassed safety record
- Minimal effect on mental acuity, in proper dosage
- Predictable patient response
- Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

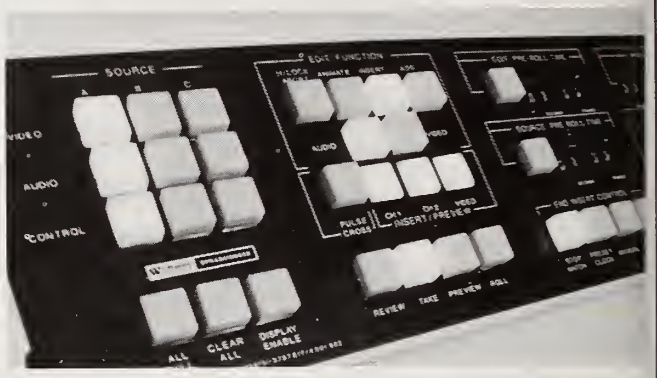
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE Roche Products Inc.
Manati, Puerto Rico 00701

COMPLETE VIDEO-TAPE SERVICES FOR THE MEDICAL PROFESSIONAL



Operation documentation
Patient information programs
Video duplication
Training tapes
Equipment consultation and design
Program design and consultation
Documentation of new techniques

ATLANTA VIDEO SERVICE
161 SPRING ST., NW
ATLANTA, GA. 30303
404 522-9068

Morris E. Chafetz, M.D.,
Founding Director of the National Institute on Alcohol Abuse and Alcoholism, and Chairman of the Board, Health Institutes,
is pleased to announce Health Institutes' first private residential alcoholism treatment facility,

FENWICK HALL

in Charleston, South Carolina.

John H. Magill, Executive Director.
Layton McCurdy, M.D., Medical Director.
Phone 803-559-2461.

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 3

ITOR
gar Woody Jr., M.D.

ANAGING EDITOR
san J. Dillon

USINESS MANAGER
B. Storey

DVERTISING REPRESENTATIVE
ary Coté

ONTRIBUTING EDITORS
rbert E. Alden, M.D., Atlanta
eston D. Ellington, M.D., Augusta
Willis Hurst, M.D., Atlanta
onald J. McKenzie, M.D., Thomasville
illiam R. Kenny, M.D., Atlanta
ck A. Raines, M.D., Columbus
arson B. Burgstiner, M.D. Savannah
itrick C. Shea Jr., M.D., Atlanta
. Calhoun Witham, M.D., Augusta

UBLICATIONS COMMITTEE/
XECUTIVE COMMITTEE OF
HE BOARD OF DIRECTORS
arnest C. Atkins, M.D., Atlanta
resident
. Hilt Hammett Jr., M.D., La Grange
resident-Elect
arson B. Burgstiner, M.D., Savannah
mmediate Past President
ichard A. Griffin III, M.D., Cartersville
irst Vice President
. W. Clark, M.D., Waycross
econd Vice President
oe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
ecretary
ames H. Sullivan, M.D., Columbus
reasurer
. C. Buchanan, M.D., Decatur
peaker of the House
ack F. Menendez, M.D., Macon
ice Speaker of the House

HE ASSOCIATION
38 Peachtree Street, N.E.
tlanta, Georgia 30309
hone: 404-876-7535
VATS Line: 1-800-282-0224
ames M. Moffett, Executive Director
tephen L. Daniel, Ph.D., Assistant Executive Director — Education
. Tom Sawyer, Assistant Executive Director — Administration
usty Kidd, Director of Legislative Activities
enneth M. Williams, Director of Public and Professional Relations
oyce Butler, R.N., Director of Medical Practice
ert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The Journal of the Medical Association of Georgia is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

193 Surgical Treatment of Spondylolisthesis
H. Dale Richardson, M.D.
C. William Brown, M.D.
205 Pulmonary Rehabilitation: Dealing Effectively with Chronic Pulmonary Disease
Donald F. May, R.R.T.
William R. Kenny, M.D.

SPECIAL ARTICLES

174 Medical Economics and Medical Ethics: Points of Conflict and Reconciliation
E. D. Pellegrino, M.D.
186 Mortality Rates of the U.S. Armies for the Year Ending June, 1862
J. J. Woodward, M.D.
196 What Do You Do For Encores?
John I. Dickinson, M.D.
217 Richmond County Sports Medicine Preparticipation Physical Examination Program
Roger M. Seklecki, D.O.
Max D. Miller, Ed.D.
William B. Strong, M.D.
Charles W. Linder, M.D.

EDITORIALS

223 Zip Code 303 Welcomes You to the MAG
Frank L. Wilson, M.D.
223 Doctor Discusses Disability Dollars
Kenneth T. Woodsides, M.D.

FEATURES

240 President's Letter/MAG's Holy Grail
Earnest C. Atkins, M.D.
229 Legal Page/Not-So-Good News for the Good Samaritan
Robert N. Berg

THE ASSOCIATION

241 New Members
242 Personals
242 Societies
244 The Ball Is in *Your* Court
Charles W. McDowell Jr., M.D.
Kenneth M. Williams

INCIDENTAL INTELLIGENCE

164 Medical Meeting Calendar
166 HEW Study Reports Certificate of Need Ineffective in Controlling Hospital Inflation
166 Host Families Needed for Foreign High School Students
166 Annual Rural Health Conference Set for April, 1980, in Boston
167 The American Association of Medical Assistants, Georgia State Society
Bannester L. Harbin, Jr., M.D.
Anne B. Dennis, CMA-A
167 Symposium on Health Care in Correctional Institutions

COVER

In this month's featured issue, Dr. Pellegrino discusses the implications of what he perceives to be the dangerous tendency of turning the valid economic necessity to contain costs into an ideology. He outlines the kinds of questions that must be confronted if medical morality is not to be subverted to economic considerations. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

MEDICAL MEETING CALENDAR

MARCH

28—*Savannah;* **DAY OF CANCER;** Category 1 credit; Contact: Shirley Preston, American Cancer Society, Georgia Division, 1422 W. Peachtree St., NW, Atlanta 30309. PH: 404/892-0026.

28—*Atlanta;* **MANAGEMENT OF THE PREGNANT DIABETIC AND HER NEWBORN;** Contact: Education Dept., Northside Hospital, 1000 Johnson Ferry Rd., NE, Atlanta 30342.

28-29—*Atlanta;* **THE TREATMENT OF ARTHRITIS — UPDATE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

APRIL

1-4—*Augusta;* **CRITICAL CARE MEDICINE;** Category 1 credit; Contact: Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

7-9—*Atlanta;* **GASTROENTEROLOGY FOR THE PEDIATRICIAN;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

10-12—*Atlanta;* **PHARMACOLOGY FOR THE ANESTHESIOLOGIST;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

10-12—*Atlanta;* **PERSPECTIVES IN SURGERY;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

10-13—*Atlanta;* **UPDATE ON FUNGAL DISEASE IN MAN;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH 404/588-3534.

11-12—*Atlanta;* **REPRODUCTIVE TRACT RECONSTRUCTIVE SURGERY;** Category 1 credit; Contact: Amir H. Ansari, M.D., Georgia Baptist Medical Center, 340 Boulevard, NE, Atlanta 30312. PH: 404/659-5211.

11-13—*Atlanta;* **FIFTH ANNUAL DOGWOOD CONFERENCE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

14-16—*Birmingham, AL;* **INTERNATIONAL CONFERENCE ON BYSSINOSIS;** Category 1 credit; Contact: Dept. of Education, American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068.

15-16—*Augusta;* **NEONATOLOGY;** Category 1 credit; Contact: Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

16-18—*Pine Mountain;* **SECOND ANNUAL PATIENT EDUCATION CONFERENCE;** Contact: Southeastern Institute for Community Health, P.O. Box 1708, LaGrange 30241. PH: 404/637-6646.

17-18—*Atlanta;* **TECHNIQUES COURSE AND MOTOR SKILLS WORKSHOP ON INTERNAL FIXATION OF FRACTURES;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

17-18—*Chattanooga, TN;* **ORTHOPAEDICS;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

18-19—*Augusta;* **DISEASE PREVENTION AND HEALTH MAINTENANCE;** Category 1 credit; Contact: Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

21-24—*New Orleans, LA;* **61ST ANNUAL SESSION, AMERICAN COLLEGE OF PHYSICIANS;** Contact: JoAnne Plummer, ACP, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

24—*Chattanooga, TN;* **MEDICINE REVIEW: GASTROENTEROLOGY;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

28-30—*Atlanta;* **48TH ANNUAL ASSEMBLY, SOUTHEASTERN SURGICAL CONGRESS;** Category 1 credit; Contact: Southeastern Surgical Congress, 315 Boulevard, NE, Ste. 500 Atlanta 30312. PH: 404/681-3733.

MAY

1—*Chattanooga, TN;* **MEDICINE REVIEW: RHEUMATOLOGY;** Contact: Dennis K. Wentz, M.D., Univ of Tenn. Ctr. for the Health Sciences 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

4-10—*Augusta;* **FAMILY PRACTICE SYMPOSIUM;** Category 1 credit Contact: Division of Continuing Education, MCG, Augusta 30912. PH: 404 828-3967.

7-9—*Atlanta;* **TECHNIQUES IN ORTHOPAEDIC SURGERY AND MOTOR SKILLS WORKSHOP ON THE INTERNAL FIXATION OF FRACTURES;** Category 1 credit Contact: Ronald G. Havican, Ctr. fo Rehab. Med., Emory Univ. Sch. o Med., 1441 Clifton Rd., NE, Atlant 30322. PH: 404/329-5535.

8—*Chattanooga, TN:* **MEDICINE REVIEW: NEUROLOGY;** Contact Dennis K. Wentz, M.D., Univ. of Tenn Ctr. for Health Sciences; 800 Madiso Ave., Memphis, TN 38163. PH: 901 528-5605.

8-9—*Atlanta;* **CHRONIC PAIN PROBLEMS OF MANAGEMENT** Category 1 credit; Contact: Associat Dean for CME, Emory Univ. Sch. o Med., 69 Butler St., SE, Atlanta 30303 PH: 404/588-3534.

12-14—*Atlanta;* **TRENDS IN CARDIOLOGY;** Category 1 credit; Contact Associate Dean for CME, Emory Univ Sch. of Med., 69 Butler St., SE, Atlant 30303. PH: 404/588-3534.

15-16—*Pine Mountain;* **EIGHTH ANNUAL PERINATAL MEDICINE CONFERENCE;** Category 1 credit Contact: Division of Perinatology, Th Medical Center, P.O. Box 951, Colum bus 31902.

22-24—*Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: As sociate Dean for CME, Emory Univ Sch. of Med., 69 Butler St., SE, Atlant 30303. PH: 404/588-3534.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

Incidental Intelligence . . .

HEW Study Reports Certificate of Need Ineffective in Controlling Hospital Inflation

A study funded by the National Center for Health Services Research [U.S. Department of Health, Education, and Welfare (DHEW)] reports that Certificate of Need (CoN) programs are not effective in lowering hospital inflation and may actually increase expenditures. The results of the study, done under contract with the Department of Health Services Administration, Johns Hopkins University, contradict the widely held belief among health planners and other regulators that CoN legislation contains health care costs.

In essence, a CoN is a statement by a governmental agency that a hospital or other health care facility meets certain requirements enabling it to expand or buy new equipment. DHEW has mandated that every state have a CoN law so that the need for all proposed new institutional health services offered in the state be determined by a state agency.

The study discovered that CoN regulations only change the direction of hospital investment from that of bed expansion to investment in new equipment and services and do not reduce overall hospital spending. The net effect of this pattern is to lower overall utilization of inpatient hospital services and raise the cost of care.

The carefully designed study compared data from those states with CoN laws to those states without CoN laws from 1968 to 1972. The effects of other factors such as insurance coverage and construction costs were considered and controlled in the statistical analysis. The authors state that, "CoN programs did not dampen hospital cost inflation from 1968 to 1972 and may have actually exacerbated it." These findings are at variance with the presumption that inflation in the cost of hospital services can be reduced substantially by CoN controls on hospital investments. The authors conclude the study by warning against the use of simple solutions such as Certificate of Need to the complex problems affecting the rise in hospital costs. For more information on the study, contact Bert Franco at MAG Headquarters.

Host Families Needed for Foreign High School Students

If you've ever dreamed of taking part in an international adventure, there is an organization that can help you fulfill those dreams. Youth for Understanding, the largest high school student exchange program in the world, will place some 800 South American teenagers with American families this month.

Georgia/Florida will be welcoming 30 Youth for Understanding students from Brazil, Chile, Argentina, Colombia, Uruguay, and Paraguay. Students and their host families receive support from nearly 1,000 volunteers in communities across the country, and 20 Regional Offices. Families provide room and board; students handle their own personal expenses.

For details on becoming a host family, contact Youth for Understanding at: 325 Hammond Dr., Suite 204, Atlanta, Georgia 30328, or call collect: 404-252-9384.

Annual Rural Health Conference Set for April, 1980, in Boston

A look into the crystal ball for a view of rural health care in the 1980s will open the 33rd National Conference on Rural Health in Boston next spring.

At the keynote session of the 2-day conference on April 17, 1980, at the Sheraton-Boston, Jacob Koomen, M.D., of the University of North Carolina, will examine the problems to be faced in rural health delivery in the coming decade and discuss programs to deal with those problems. Registrants will then participate in a round-table discussion led by Ken Cheatham, of the American Farm Bureau Federation, who will serve as primary respondent to Dr. Koomen's futuristic evaluation of rural health.

Seminars during the conference will deal with self-care, home health and hospice care, nurse practitioners, mental health in rural settings, emergency medical services, extrication from farm equipment, the increasing demands on rural hospitals, health planning, and other matters of concern to those involved in rural health. Leading authorities on and professionals in these topic areas will serve as speakers, seminar directors, and panelists.

A series of continuing medical education courses designed for physicians treating rural populations will be presented during both days of the conference. These will include wound closure, primary management of head trauma, other trauma in agriculture, poisonings, zoonosis, replantation microsurgery, sports medicine for rural schools, and nutritional assessment and management in rural areas.

Co-sponsors of the conference, with the American Medical Association, are the American Hospital Association's Center for Small or Rural Hospitals, the American Nurses Association, the American Pharmaceutical Association, the Cooperative Extension Service of the United States Department of Agriculture, the Farm Foundation, the Massachusetts Medical Society and the National Safety Council.

The American Association of Medical Assistants, Georgia State Society



Lester Harbin, M.D., from the Harbin Clinic in Rome, works closely with medical assistants in his practice to insure quality care for his patients. (L to R): Vera Ables, L.P.N., AAMA corresponding secretary (Rome chapter), Charlotte Williams, AAMA President-elect (Rome chapter), and Nancy Eleam, CPS, President-elect of the statewide AAMA.

There is a professional paramedical society in Georgia that deserves your attention — The Georgia Society of the American Association of Medical Assistants (AAMA). Continuing Education is the primary concern of this organization. Three home study courses are now available: *Anatomy, Terminology, and Physiology; The Humanistic Medical Assistant* (human relations); and *Specimen Collection and Preparation.*

The AAMA offers a Certification Examination designed to evaluate professional competency. Medical assistants, medical assisting educators, and students who successfully complete the examination are entitled to use the CMA (Certified Medical Assistant) designation after their names.

The annual meeting of the AAMA, Georgia State Society, will be held at the Holiday Inn in Valdosta April 17-20, 1980. Medical assistants throughout Georgia (members and non-members) are invited to hear experts in medical and related fields present educational sessions and workshops. Marian G. Cooper, CMA-C, Chairman of the AAMA Continuing Education Board, will be the keynote speaker.

For information on membership in the Georgia State Society, American Association of Medical Assistants, contact Dianne Frederick, CMA-A, President, 6506 Capstone Circle, Tucker, GA 30084.

(Reported by Bannester Harbin, Jr., M.D., Rome, and Anne B. Dennis, CMA-A, Columbus.)

Symposium on Health Care in Correctional Institutions

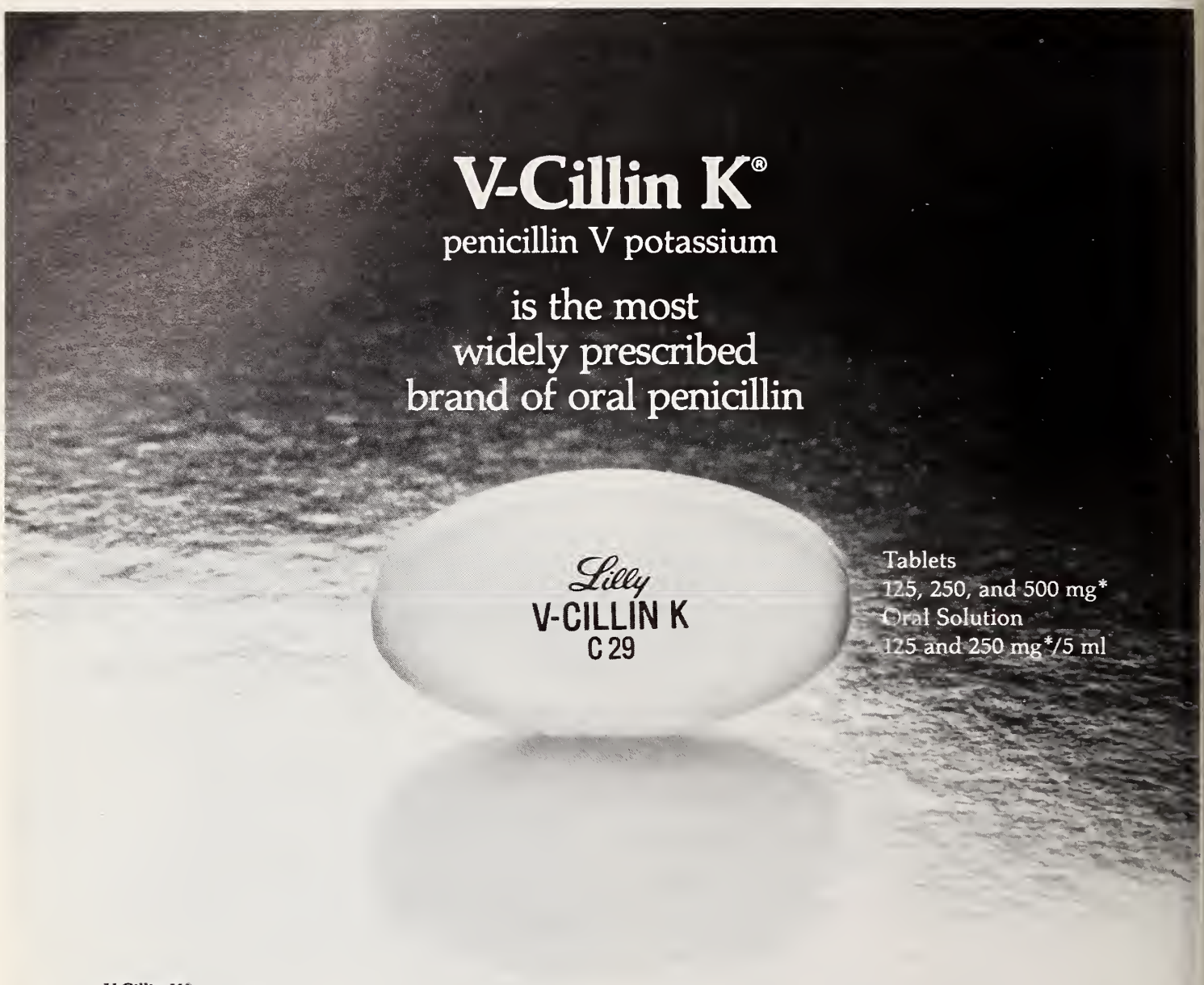
The Medical Association of Georgia's Committee on Prison Health Care, chaired by Charles Allard, M.D., of Decatur, is presenting a special Symposium on Health Care in Correctional Institutions on April 12, 1980, at the Memorial Medical Center in Savannah, Georgia. Four panels will be discussing specific issues in the delivery of health care in correctional institutions which have been identified over the 4 years of the American Medical Association (AMA) Health Care in Jails Project in the State of Georgia. These issues are: legal issues, detoxification of alcohol and drugs, mental illness, and pharmaceuticals.

J. Rhodes Haverty, M.D., of Atlanta, and Joe Rowan, from the AMA, will speak on State Jail Standards which include medical and health care standards. W. Douglas Skelton, M.D., of Atlanta, and Derril Gay, Director of the Department of Mental Health and Retardation, Georgia Department of Human Resources, will speak about mental illness in jails and prisons. Dr. Skelton is the former Commissioner of the Georgia Department of Human Resources. G. Douglas Talbott, M.D., Atlanta, who directs the Disabled Doctors Program, is moderating the panel on detoxification. The guest speaker is Dr. Maxwell N. Weismen who directs the Alcohol Control Administration in Maryland.

This Symposium meets the criteria for 8 hours in Category 1 for the AMA's Physician's Recognition Award.

Those wishing to attend are encouraged to make early reservations for a lodging of their choice. A special tour of the medical facilities at the new and AMA accredited Chatham County Jail will be conducted at 7:00 p.m. on April 11 for the Symposium participants. Call Dorothy Parker (404) 875-5546 (INWATS 282-0224) for more details or to pre-register.

Buy and Sell in the *Journal*'s Classifieds



V-Cillin K®
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

***Equivalent to penicillin V.**

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

900416

medicard



I am proud to present the one card that increases your cash flow -- MEDICARD.

Whether your facility is a one person operation or a large health care group, we offer three day turnaround on your funds, less a minimal discount fee. In addition, we prepare tailor-made billing systems for your particular needs, and offer accounts receivable programs for your consideration.

As a provider of health care, you may offer to MEDICARD holders the opportunity to charge visits to your office, the hospital emergency room and outpatient clinics, prescriptions, eyeglasses and contact lenses, laboratory tests, wheelchairs, crutches and braces, hearing aids, physical therapy, convalescent and special health care -- anything and everything for good health.

MEDICARD was created to provide consumers with a line of credit for medical and health care expenses at a time when these costs are skyrocketing. We provide a substantial line of credit so that people do not have to dig into their savings or borrow to the limit of their bank credit cards.

Our research has shown there is a great need for these services. We stand ready to offer you, and the community, financial good health.

Here's to good health, for everyone, with MEDICARD.

Sincerely,

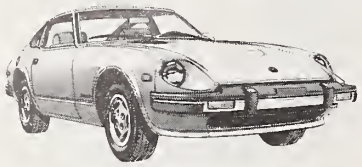
Harold A. Dye, President

MEDICARD INCORPORATED
31 Executive Park Drive / P.O. Box 95329 / Atlanta, Georgia 30347 / (404) 325-2009

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

Serving the General Insurance needs of the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Insurance AGENT

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®



8-3305 (Y371A)



Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.



Tagamet®

brand of

cimetidine

How Supplied:

Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

SK&F LAB CO.
a SmithKline company



The gold coin you can buy with confidence.

It's no accident that the Krugerrand is the world's best-selling gold coin. Unlike many other gold coins, it is intended for people who want to acquire gold. It contains precisely one troy ounce of gold, so that determining its approximate value is as simple as checking the day's gold ounce price in your local newspaper. (There is a small charge for minting and distribution.)

The Krugerrand is widely recognized for its weight and purity. That means you won't have to pay the costly assay charges that may accompany gold bullion or wafers.

Its size (about the size of a Kennedy half dollar) is convenient for mounting as jewelry, displaying in a coin frame or stashing away in your safe deposit box.

We at Mintmaster have been in the business of buying and selling coins for many years. Our experience and reputation stand behind every South African Krugerrand you buy.

The Krugerrand.

The world's best way to own gold.

MINTMASTER
COIN GALLERIES
3272 Peachtree Rd. N.E.
(404) 266-1074



Medical Economics and Medical Ethics: Points of Conflict and Reconciliation

E. D. PELLEGRINO, M.D., *Washington, D.C.**



Edmund D. Pellegrino, M.D., President of The Catholic University in Washington, D.C., was the featured speaker at the Abner W. Calhoun Lecture at the 1979 MAG Scientific Assembly.

JOURNAL
of the medical association of georgia

In his classic work, "Religion and the Rise of Capitalism," R. H. Tawney warned that "Economic ambitions are good servants but bad masters."[1] My theme for this year's Abner Calhoun Lecture is an extended footnote to Tawney's assertion as it applies to a dangerous tendency I perceive in today's debates and legislative proposals about medical and health care.

I refer to the transformation of the valid economic necessity to contain costs into an ideology — a self-justifying principle that threatens to assume quasi-moral stature. One consequence is the self-righteous pursuit of economic goals that may obscure our obligations to the sick. Another is the commercialization of the healing relationship by the growing pressure to use competition as a cost control measure.

Both consequences tend to subvert the traditional moral obligations of physicians to individual patients. After all, the fundamental promise in every medical encounter is the good of a particular patient — not society, the family, the physician, or economics. The micro-ethics of the care of individuals can suffer badly if we turn too assiduously to the macro-ethics of social good.

Before elevating economic considerations to moral stature, then, we must reflect on their potential conflict with the premises of medical morality. Without denying the terrible reality of rising medical care costs, we must seek morally defensible solutions that satisfy the legitimate expectations of those who are sick when they consult physicians or other health workers.

Let me say as forcefully as I can at the very outset that I am acutely aware of the crushing reality of rising costs, of the competition between expenditures for health and other human goods and services, and on the deleterious consequences of an overinfatuation with medical solutions to all of life's problems. Resources are limited; they are often under- and over-utilized in medical care, and optimizing their use is rational and necessary. Granting the full importance of these economic exigencies, we must not let them obscure the preeminence of moral considerations in the care of the sick. This must be so even as we enter the new decade of the 80's, with their dark forebodings of economic disaster for our nation and the world.

My theses will become clear, I believe, if we proceed as follows: first reminding ourselves of the central moral obligations in the medical encounter, then examining the nature of some current and economically inspired models of care and their points of conflict with medical morality. And finally, suggesting a stance for physicians that reconciles economic sensitivity with medical ethics.

I. The Central Canons of Medical Morality

I have recently suggested in some detail the need for the grounding of medical morality in a philosophy of the healing relationship, and I will therefore touch briefly on only one crucial point here.[2] We can most expeditiously uncover the point most relevant to a potential clash between medical ethics and economic ideologies by reflecting on one question —



H. Hilt Hammett Jr., M.D. (L), and Earnest C. Atkins, M.D., listen as Dr. Pellegrino discusses the dilemma doctors find themselves in as a result of modern economics' challenge to basic medical ethics.

* Dr. Pellegrino is President, The Catholic University of America, Washington, D.C. 20064. This paper was delivered as the 1979 Abner Calhoun Lecture at the Scientific Assembly in Atlanta sponsored by the Medical Association of Georgia.

what expectations may a patient legitimately hold when he enters a healing relationship with his physician? What does the physician promise implicitly and uniquely to each person who seeks assistance?

At a minimum, the physician simply by presenting himself as such to a patient and agreeing to care for him promises that all his special skill and competence will be put at the service of the patient. The prime focus of all the physician's activity is the good of the person who presents himself here and now — not some distant patient who may be more worthy, not the good of society or the family, and certainly not the good of the physician or the institution he may serve.

The healing relationship is based in a relationship of trust, in a promise of assistance and in a covenant, arising out of the vulnerability of the sick person, the capabilities of the physician, and his act of profession.[3] The patient expects the physician to become his agent, to manage his recovery in his (the patient's) best interests, and to take every reasonable measure to make him well again or to ameliorate his symptoms. The essential thing is the patient's expectation that whatever is advised or done will be in his behalf and in the interest of his healing.

This is the moral center of medicine, the moment of clinical truth, the point on which the physician's science and art converge. Deciding what is right and good for a particular person and acting as his agent in carrying out that decision is what gives medicine its special character among human enterprises.

The micro-ethics of the care of individuals can suffer badly if we turn too assiduously to the macro-ethics of social good.

In democratic societies, the patient does not expect his physician to be the agent of economic policy or to introduce social cost/benefit considerations in making his clinical decision. The physician, to be sure, operates within broadly defined public policies and is never totally independent of them. But he also has a responsibility to resist such policies when they are detrimental to his first trust — the good of his patient. The physician's prime obligation is as his patient's advocate unless the patient's welfare immediately and urgently threatens the welfare of others (the patient with a dangerous contagious disease or the dangerously psychotic). A distant threat to the economic well-being of society cannot compete morally with the immediate and urgent need of the patient.

None of this implies that the physician should be socially irresponsible, that he must satisfy the patient's every whim, or that he should not participate in public policy decisions about the optimal use of resources, their allocation, and efficient application. What is implied is that it would be a violation of the obligation of the covenant between physician and patient not to place this patient's concerns and needs above economic, social, and political considerations. The physician-patient relationship takes place in a societal frame to be sure, and neither party can totally evade social responsibility. But when micro- and macro-ethics are in conflict, the interests of the patient can be set aside only in the most exceptional circumstances.

II. Use and Abuse of Economically Inspired Models of Care

The interpretation of medical morality just outlined must come increasingly into conflict with current and future models of care designed primarily to contain costs. These conflicts and the "tragic choices" they entail must be recognized and dealt with consciously. They will not disappear, and to ignore them can be fatal to both our moral and economic sensibilities.

Some of the conflict arises from an abuse and misapprehension of what can be expected from economics, and some derives from specific measures and attitudes inherent in the currently debated and often contradictory models of cost containment. Let us look briefly at these two sources of conflict between medical morality and economic policy.

A fundamental aim of economics is to seek an optimal allocation of scarce resources to meet human needs. Economics is competent to deal with the analysis of means of allocation and their consequences, with questions of efficiency, productivity, cost, price, with benefits at the margin, and even to assign approximate dollar values to illness produced, loss of life, function, or social contribution. What economics cannot do is to determine what is right and good in the moral sense for individuals or society because moral considerations by their very nature take precedence over all other considerations.

Economics is not competent within its own methodology to define the goals and values of society or to override considerations of personal morality. Its special function is to analyze the economic consequences of proposed policies as objectively as possible so that options can be chosen rationally. It is interesting that in its recent intellectual history, economics itself recognizes this limitation. As Daniel Fox shows, the early economists were far more prescriptive in their recommendations than their present-day colleagues.[4, 5] Unfortunately, those who make public policy often expect more from economics than its practitioners would themselves claim.

It may happen that what is good in an economic sense is also morally good, but the connection is not

a necessary one. When economic good conflicts with other definitions of the good, some other discipline is required to establish a priority — either moral philosophy, theology, or both, depending upon our belief systems. Economics cannot substitute for the moral sciences, though they need its analyses to ground their deliberations. In the end, health care economics must meet the tests of morality like every other human endeavor.

Viewed from the standpoint of good economics, the health care market abounds in reasons for escalating costs: it is provider dominated, demand is uncontrollable, maldistribution is inevitable; demand rises with rising affluence; the incremental value of investments in new technology may be marginal or negative; increasing the input of resources does not necessarily mean more health for the nation.

Granting the full importance of economic exigencies [of rising costs and limited resources], we must not let them obscure the preeminence of moral considerations in the care of the sick.

Equally familiar is the range of economic measures proposed to deal with the factors that contribute to rising costs: price control, expenditure ceilings, rationing of expensive or unnecessary services, limiting resource input, centralization and sharing of facilities and equipment, reducing demand through disincentives, encouraging competition, limiting care for those with little prospect of recovery to socially useful lives.

Varying combinations of these factors are incorporated in most of the recently proposed models for control of medical care expenditures. They were summarized in a recent conference on the ethics of cost containment held in 1978.[6] A few examples from this conference will illustrate the kinds of moral choices and conflicts that different economic philosophies and assumptions can produce.

First is the free-market approach, which is energized by the attractions of competition among providers as a cost-lowering device. Health on this view is considered no different from the purchase of any other commodity, whether it is beer, pantyhose, or bread.[7, 8] Physicians have property rights over their skills; they may sell them to whom they choose and under conditions they set. People can buy as much as or as little care as they choose. They can shop among HMOs, insurance plans, hospitals, and clinics for the best buy. Some concession is made to the poor, who would be covered by some minimum level voucher system, but on the whole, the consumer buys and gets what he can afford.

In direct opposition are the regulated government-insured consumer-controlled models providing extensive coverage and favored by many unions.[9] These models are predicated on the unworkability of free market systems. They emphasize rigorous national planning and regulation of the distribution of services, personnel, and facilities, so that equity of access, availability, and comprehensive services will be assured.

Another approach, also based on the unworkability of free market systems, is the public utility model.[10] Proponents of this view hold that health care is a civil right and that government should assure equitable distribution, as it does with power or telephone service, by franchising and regulating delivery. In this way, the burdens of cost containment will not be borne primarily by the poor. Emphasis is on primary and preventive services for large numbers rather than expensive technology for the few.

Each of these opposing models uses a different set of economic assumptions to achieve the common aim of cost containment, and each raises different challenges to medical morality.

In the free market models, the prime principles are the freedom of the provider and competition as an alternative to public regulation. These measures are intended to increase the efficiency of providers and motivate them to lower prices. Consumers would be sensitized to costs through incentives to choose cost-effective options. Sharing by consumers in the costs of over utilization or expensive procedures is expected to reduce demand for care.

Competitive models place efficiency and cost reduction above equity of access and availability, threaten the previously accepted principle of a single standard of care for rich and poor, and militate against comprehensive and preventive care in favor of minimum affordable care. But how free is the consumer when he is ill and needs more care than he can afford? When the major purchasers of care — government and industry — contract with the lowest bidders, the consumer's choices are limited even under the best circumstances. How do these limitations affect the physician's obligation to seek the best interest of his patient? Is health care really in the same category of commercial exchanges as beer and bread? What do we say about the kind of society we want, and what we think most important in these competitive models?

What does the physician promise implicity and uniquely to each person who seeks assistance?

The competitive models aim to discourage the use of hospitals, extensive diagnostic work-ups, expen-

sive technologies, and specialist referrals. Disincentives are needed to avoid abuses of these resources. But how far can we go in this direction without compromising adequate, to say nothing of optimal, care? How much disability and suffering will disincentives produce among those who need but cannot afford these "extras"? When does an "extra" become an essential?

The government-insured models, whether consumer controlled or operated as public utilities, pose moral problems, too. They aim for comprehensive coverage and removal of the financial obstacles to equity in accessibility and availability of care. They are in this way more morally responsible than the competitive models. But these models must also practice cost containment, and they do so by bureaucratic means — strict planning and control of distribution of facilities and services and regulation of providers — their supply, fees, location, specialty, and number trained.

These models raise questions of medical morality as serious as those with the competitive models. The benefits chosen, the groups covered or excluded, the choice of volume, primary and preventive care versus intensive acute care, can run counter to the need of individual patients. Value choices are made by an institutional provider rather than the individual consumer. These choices may not represent what patients *need* when they are ill as opposed to what they want when they are well.

Institutional and corporate providers — government, HMOs, unions — must shop for contracts with the most economical providers just as individuals do in the competitive models. Efficiency, productivity, and standardization become important considerations, with constraints on the physician's discretionary privileges in dealing with his patients. The less affluent may be a little better protected than in the competitive models, but transferring value decisions to a corporate entity is no guarantee of just or moral choices.



There are some specific measures common to almost all the models proposed to curtail costs. Let us look quickly at a few of them to see the moral dilemmas they generate.

One beguilingly popular measure at the moment is the limiting of the use and development of expensive new technologies. There is no doubt of their contribution to rising costs but the utmost care must be exercised in setting restrictions. This is evident in the recent history of the CAT scanner. Legislators, planners, economists quickly seized upon this instrument as the prototype of technologic overkill. They called for cost-benefit analyses, rationing, centralization, and sharing of available instruments. It became rapidly clear, however, that the CAT scanner offers distinctive advantages in neurologic diagnoses.[11, 12] It is a non-invasive, complication-free ambulatory technique, as good as or superior to existing methods, especially useful in reducing craniotomies for head trauma, and replacing such disagreeable procedures as pneumoencephalography in the diagnosis of tumors.

A distant threat to the economic well-being of society cannot compete morally with the immediate and urgent need of the patient.

The question now is whether we can morally justify denying patients with suspected brain tumor, cerebral hemorrhage, or subdural hematoma the benefits of this device. Charges are still high; savings are difficult to demonstrate. What is the meaning of cost effectiveness in such instances? What is the human value to a particular patient of a speedy diagnosis by non-invasive means? What is the "added value" of assuaging anxiety when a brain tumor is suspected?

Is centralization and sharing defensible with a procedure of such evident utility in so widely distributed a problem as head trauma? Head injury does not distribute itself according to hospital size or availability of instrumentation. Moving patients with head trauma adds risks; decisions about craniotomy cannot be safely postponed.

All new technology does not evolve in this clear way, of course. Many new techniques are marginally effective or not at all effective. But each new advance may pose similar moral questions. We need not be victims of the technologic imperative to question the advisability of restricting the search for new techniques. How do we calculate the benefits of a new breakthrough? Even the technologic failure paves the way for more successful techniques. It is true that overall morbidity and mortality are as dependent upon sanitation, jobs, and housing as on technologic breakthroughs. But how can we know

the trade-off in advance? Smallpox immunization eradicated that disease long before we could have hoped to do so by sanitary measures, even if that were possible.

Another conflict between economics and medical morality arises in the current move to reallocate funds from "curative" to "preventive" medicine. Here the conflict is less immediate than in the case of an effective new technology. There is no question that the cumulative economic impact (disability, loss of productive days, cost of care) consequent on poor personal health habits is enormous. If we could eliminate smoking, alcohol, poor driving, poor diets, sedentary living, and dangerous working environments, billions of dollars would be available for reallocation for other needed human services. Why not deviate limited funds from the care of those with incurable disorders in which there is only a dubious marginal benefit in treatment or from the severely mentally ill whose future even after recovery may be short lived?

The question is economically reasonable but again the complexity of human existence intrudes. What do we do when the funds allocated for "curative" medicine are exhausted? Healthy people may agree to a policy of prevention. When they become ill and are in immediate need, they are far less likely to think about the economic impact of care versus cure and prevention. What physician or hospital can turn away the sick in favor of the future social benefits of those who will *not* get sick? Where is the line to be drawn between effective and palliative treatments, or between needed and "unwarranted" care? Is there a moral justification for not treating those who persist in smoking or drinking? What advanced society, let alone what health professional, could justify this kind of statistical morality?

The healing relationship is based in a relationship of trust. . . .

Often overlooked by the enthusiasts for prevention is the fact that truly effective prevention might actually increase the total medical care costs. The number of aged people increases; they would live long enough to develop incurable chronic disorders.[13] Prevention presumably would afford more healthy years in mid-life but also more years of ill-health toward the end of life. This would not be an argument against prevention, but it shows again how economic end points must be interpreted in the light of other than economic values.

Again, the traditional canons and expectations of medical morality demand that we help those who are ill *now* and present themselves for care *now*. No matter what large scale policy decision may have been made, the physician cannot reject the person in need and remain faithful to the obligations he/she incurs in agreeing to treat. It is not likely that given the choice, society would wish to change its expectations of physicians so drastically as to make them instruments of economic policy rather than advocates for the individual patient.

The same considerations pertain to a variety of other measures aimed at containment. Let us suppose we place a "cap" on all hospital construction, as has been proposed, though recently rejected by the Congress. On the surface, this seems very reasonable. Limiting the number of new beds should encourage better use of existing beds and avoid unjustified utilization and duplication of facilities.

A fundamental aim of economics is to seek an optimal allocation of scarce resources to meet human needs.

But again we must examine the medical-moral implications. When do existing beds become so obsolete that they are no longer suitable for caring for the sick? What is the proper use of a hospital bed? Often the crucial factor in recovery is getting the patient out of the home or work environment. A medical condition like uncomplicated peptic ulcer might be as effectively treated on an ambulatory basis, but it might take longer and result in less understanding of the psycho-social factors in causation and less complete cure than if the patient could break the cycle of stress more completely in the hospital.

What dollar value do we place on those "extra" days in the hospital for a young mother recovering from pneumonia or surgery? Or the days "consumed" by the elderly man medically ready for discharge but as yet unable to cope with daily life without completion of family arrangements? Are our resources so constrained that standardized rules about how many days it takes to treat a disease should take precedence over the number of days it takes to treat a patient? Nothing more completely violates the uniqueness of illness in individual patients than standardized and formularized care. Granting the existence of abuses of hospital bed use, the problem now seems to be to rescue the patient from overzealous application of formulas that carry the sanction of peer review.

What do we do about mounting pressures to deny expensive treatments to patients with limited prospects for survival or limited chances for eventual recovery to a "productive" or "socially meaningful" life? It has been shown that 70% of the most critically ill patients, despite maximal therapeutic intervention, do not survive beyond 12 months. Yet

these same patients consume resources — money, people, equipment, time, and energy — in enormous amounts.[14] We cannot deny these expenditures to those patients when they present themselves, even though the economics of resources allocation would suggest such a course. How should we resolve the conflict between high costs and low social benefits for the care of the retarded, the aged, the patient in intensive care, the patient needing to be dialyzed, and the dubious social benefits of such treatment? Is the physician free to apply economic considerations when his covenant is with his patient and not with society? Some would have physicians act as economic monitors. Others would have them place social benefit before individual needs and desires.

"Cost containment" and "everything for the patient" are opposing ideologies, equally to be avoided. Neither is morally defensible when applied as an absolute.

Every measure aimed at rationing scarce resources entails ethical dilemmas of this kind. The tension between micro- and macro-ethics promises to become more troublesome as costs mount further and resources become more obviously scarce. "Cost containment" and "everything for every patient" are opposing ideologies, equally to be avoided. Neither is morally defensible when applied as an absolute. What is increasingly demanded is some way to balance these conflicting obligations, each of which binds the physician to varying degrees. Let us turn to some of the ways in which an equilibration can be rationally and explicitly achieved.

III. Equilibration of Moral and Economic Obligations

There is much that physicians can do without violating their fiduciary responsibilities to their patients. Without looking for a neat formula to resolve every conflict, let us look at some of the simpler and obvious measures.

To begin with, the *primary* obligation of the physician to his patient does not excuse him totally from social and economic concerns. We have already noted those exceptions when the patient's "good" might be a threat to public safety. Yet the physician must not take advantage of the vulnerability of the sick patient to advance his own, or even his nation's, social or economic philosophy. The dangers in ignoring this principle are too well attested in recent history and need no recounting here. The physician is nonetheless obliged, both as a citizen and as a member of a profession with a corporate responsibility to society, to take both economic and social concerns very seriously.

As citizens with special knowledge, physicians are obliged to take an active part in decisions that determine health care policies and expenditures. They have the obligation to define alternatives, to explicate the moral dilemmas of a policy, and to offer those modifications which will prevent a policy from overriding human concerns. To do that, they must first provide reliable data on the efficacy and efficiency of medical procedures. They alone can provide the technical input essential to sound economic decisions.

This obligation will become particularly pertinent if, as some economists advise, we move toward cost-effectiveness analyses that take into account quality of life in establishing priorities.[15]

When they participate in public decisions, physicians should not assume they know what is "good" for all patients or for society. As physicians, they have a considerable prerogative in technical matters, but no special prerogative in making value decisions. Ultimately, the decision to follow a particular economic policy must turn on a question of values: What we think the "good" life may be, what is "worthwhile" and what is not for individuals and society. On such questions the physician is free to propound his personal values, but he is not automatically an *expert* on values. Failure to make this last distinction often damages a physician's effectiveness in policy-making bodies and casts doubt on his credibility.

Whatever may be his personal values, the physician has a choice like any other citizen to conform to or oppose a public policy. But in dealing with the individual patient, his personal economic preferences or social philosophy must take a second place. If they are so important to him that he must express them through his treatments, then he must make that fact known beforehand. In that way, the patient can exercise the option to reject him in favor of another physician. Under no circumstances should the physician use economic constraints to "punish" patients whose values or lifestyle he abhors. Too often the physician's hostility to the alcoholic, the homosexual, or the sociopath is justified by cost/benefit criteria.

One moral dilemma generated by these models is the limiting of the use and development of new technologies.

These caveats notwithstanding, the physician cannot assume the attitude that "everything possible" must be done for everyone. While his estimate may not be entirely accurate, there is an important truth in Eli Ginzberg's assertion that each physician adds some $350,000 to the cost of health care annu-

ally.[16] The physician is, and must remain, at the center of the clinical decisions that determine those costs. He has, therefore, an unavoidable obligation to his patient and to society to contain that segment of costs over which he has direct supervision.

It is perhaps preferable to speak of cost consciousness rather than cost containment. The former attitude imposes a responsibility but does not make costs the prime consideration. Cost consciousness can be consistent with both good economics and good medicine, since it is a more flexible and more prudent stance. It errs on the side of the vulnerable person — the one who is in need, and is therefore consistent with the helping and healing role of the physician. Some of the measures that could fit the rubric of cost consciousness responsibly are as follows:

The first is to cultivate true diagnostic elegance, in the scientific sense of that term, to order only those tests which answer a specific question and which lead to some practical decision. Much more critical attention to how much evidence is sufficient for a patient's diagnosis, or better, for taking a clinical action is needed. "Shotgun" and "roulette" work-ups to cover all bases are expensive, non-conclusive, and even dangerous. Clinicians need to know when a test makes only a marginal contribution, when diagnostic certitude is possible and when it is an illusion. This is one of the major deficiencies in medical education today.

Physicians must understand something, too, of their own diagnostic and therapeutic "style."[17] The compulsive diagnostician keeps testing beyond the law of diminishing returns; the therapeutic enthusiast keeps trying medications beyond the limits of reason and safety; the action-oriented physician likes to "do things"; the meditators prefer to do nothing "judiciously." Each in his own way, or in specific cases, may produce excessive costs, which on critical examination are indefensible, clinically as well as economically. Too many tests and procedures, too many drugs, too many consultations, and too many x-rays, are the marks of disorderly clinical thinking as well as cost insensitivity.

Even more fundamental is a mastery of the basic skills of history-taking and physical diagnosis. As a consultant for many years, it is my experience that the most costly and dangerous errors in diagnosis result from failure in these basics and not in failure to order enough tests. Unfortunately, lawyers and courts are ignorant of this fact. Much of the "excess" use of procedures, tests, and x-rays constitutes defensive action against a litigation-happy society. Judging the adequacy of a patient's work-up by standardized criteria when the criteria themselves have not been rigorously justified is poor logic, poor law, and poor care.

The cost conscious clinician should be severely critical of his own use of the hospital, of consultants, and of unreasonable demands of his patients for the use of both. The hospital is not to be used to alleviate minor inconveniences in the lives of patients or physicians. Surgeons with unfavorable morbidity statistics or over-eager scalpels must be identified and avoided. Enough has been written about "unnecessary surgery" to indicate how abhorrent it is to good medicine as well as to good economics. The same applies to the "test-happy" internist and the "procedure-happy" subspecialists.

One measure to fit the rubric of cost consciousness is to cultivate true diagnostic elegance.

The physician has a moral obligation to educate his patient to less costly methods of care, especially when, as is usually the case, they are more consistent with good clinical practices. To be sensitive to the patient's needs does not require being submissive to his every whim. Ambulatory care is often preferable to hospital care. Penicillin for a viral infection, tonsillectomy or hysterectomy on demand, and even the "latest" drugs are invitations to unnecessary expense and serious side effects as well.

Even some of the measures now accepted by the profession in the interests of cost containment and quality-control need scrutiny. Peer reviews of hospital utilization and PSRO activities can themselves become self-justifying. Peer pressure accompanies peer review. Simply because there is "agreement" on some standardized stay for an illness does not give moral justification for refusing to pay for, or to hospitalize the patient whose needs are not "standard." One unfortunate response to regulation is to "give up the struggle" for optimization of care.

More critical studies are needed of the cost benefit ratios in established patterns of care. For example, a recent study comparing ambulatory care by internists and family practitioners showed that the former spent more time and used more tests than the latter.[18] Neither spent much time in therapy for emotional problems. The paper did not say whether quality of care was different in the two groups, but it raised very important questions about the relationships between quality and cost benefit. I have raised similar questions here and would emphasize their moral implications as well.

To practice cost sensitivity, then, requires first of all that the physician be expert in the basic tools of his own craft. Properly used, these tools will make him discriminating enough to use only those means which are most effective in meeting the patient's needs and no others. He must, in short, practice an

economy of means in his daily work. This is the precise point at which the clinician can best equilibrate medical morality and medical economics so that the two become synonymous and not competing obligations.

I cannot in this regard ignore another potential conflict, that between the patient's good and economics of the physician himself. Some physicians have commercialized their relationships with patients by an excessive concern with fees and methods of payment, by refusal to see medicare and medicaid patients, or by abusing and even defrauding third-party payers. Each physician must rigorously examine himself to answer truthfully whether he is not subtly falling victim to the "doctor's dilemma" that Bernard Shaw so scathingly portrayed in his play of that name. Judge Barnes of the Federal Trade Commission has recently ruled that medicine is a commercial enterprise to be judged as business. He sees professional ethics as a self-protective device. How much consolation do physicians give his view when they overemphasize economic autonomy, ignore problems of distribution of care, over-utilize diagnostic and therapeutic procedures, and make medicine a business enterprise?

Cost consciousness, as opposed to cost containment, can be consistent with both good economics and good medicine. . . .

Generalizations are dangerous here, and I have no wish to fuel the angry and sweeping allegations of the more rabid physician-baiters who suspect all of us of fiscal foul play or exploitation of the sick. However, personal economic morality must accompany professional morality. The two are always mutually re-enforcing in the good physician.

In this respect, there is a serious misunderstanding among physicians and medical educators about what constitutes "medical economics." All too often it is identified with the good business practices attendant on running an efficient office. Physicians do need better education in economics but the emphasis must be on its uses and limitations, on how to analyze costs, productivity, resource allocation, and the like. Particularly important is a better knowledge of how to analyze marginal benefits against marginal costs for given procedures.

The growing concern about fees is underscored by a recent study of the D.C. Blue Shield fee structures.[19] The cost escalating effects of the reasonable charge principle are underscored, as are the effects of the dominant influences of procedure-oriented specialists. While such studies are as yet limited, they do point to the need for a deeper concern by the whole profession for the coming clash between the freedom to set fees and the rising cost of medical services. The profession has an opportunity I hope it will take, to examine itself before regulatory measures are proposed on what may be limited evidence.

But even this will not be enough. There must also be equilibration on the broader scale of social and public policy. Even the cost-sensitive clinician must function under policies and in institutions which can re-enforce or frustrate his efforts in the care of individual patients. Certain fundamental questions upon which policies ultimately depend must be faced much more explicitly than they have been up to now.

For example, some economists and physicians are fond of telling us that the American people do not place health very high on their list of priorities. This view is based on surveys mostly among healthy people. The priorities of those who are ill can be drastically different — as any clinician will attest who has attended even the most ardent cost-containing economist or health planner. We do need to know more accurately where the American people place medical care and to what extent they are willing to compromise their customary expectations of physicians and hospitals that "everything possible" will be done in their interest.

The possible compromises of this concept contained in many of the decisions now facing us have not been made clear enough to enable the public to make choices. Instead, planners and legislators respond frenetically to one crisis after another — cost escalation, variable quality of care, medicare and medicaid abuses, excessive demand for new technology, needless prolongation of life in the incurable, to mention a few. Piecemeal legislation is promoted with catchy phraseology to answer each crisis, but one solution is rarely related to the others, even more rarely are the compromises of one piece of legislation imposed on other needs and services. We hear constantly of limited resources but infrequently what a shift in priorities means for those services we already count upon.

The public debate on resource allocation, health policy, and legislation must be conducted in a more productive way. Alternatives must be more clearly delineated. For example, many planners speak of limiting health expenditures to 10% of the Gross National Product. What is the justification for this figure? Everyone speaks glibly of the "American people" and what they will, or will not, tolerate, or what they want besides health care. Granting they receive their money's worth, and granting it is efficiently and honestly provided, the figure may be higher or lower.

Nor do we really know what people want medicine for. Some argue that medicine should confine itself to "high" technology and only effective therapeutic measures. Others take the contrary view that medicine is really the instrument to total health and happi-

ness. Still others emphasize the helping and caring functions as of equal value with the specifically curative. Which of these alternatives we choose will profoundly alter our expenditures, the kinds and number of health professionals we educate, the types of institutions we build, and the minimal benefits we will provide under national health insurance, more so than any adjustments and fine tuning we may make in efficiency, increased productivity, fee regulations, or expenditure ceilings within the system.

Ultimately, our health economic policies must reflect what it is we expect in the way of health and medical care in an advanced democratic society.[20] Is primary care a human need so basic that it is an obligation of a civilized society? Does such an obligation apply to other forms of care as well? Is it possible to be a free human and to pursue other human ends if one is ill or in distress? Is health, with security, food, housing, and civic liberty, among the first principles of civilized life?

These are questions of values, of what we as a society consider to be the things for which we will sacrifice. Would this sacrifice include providing the most humane care even for those whose social utility is marginal or questionable? An economically inspired morality would answer that question one way, a morality inspired by care and solicitude for others would give a different answer. How much of our amusements and diversions — the tremendous expenditures, the almost universally accepted forms of chemical coping, alcohol, coffee, tobacco — would we sacrifice for the security of medical care available and accessible to all?

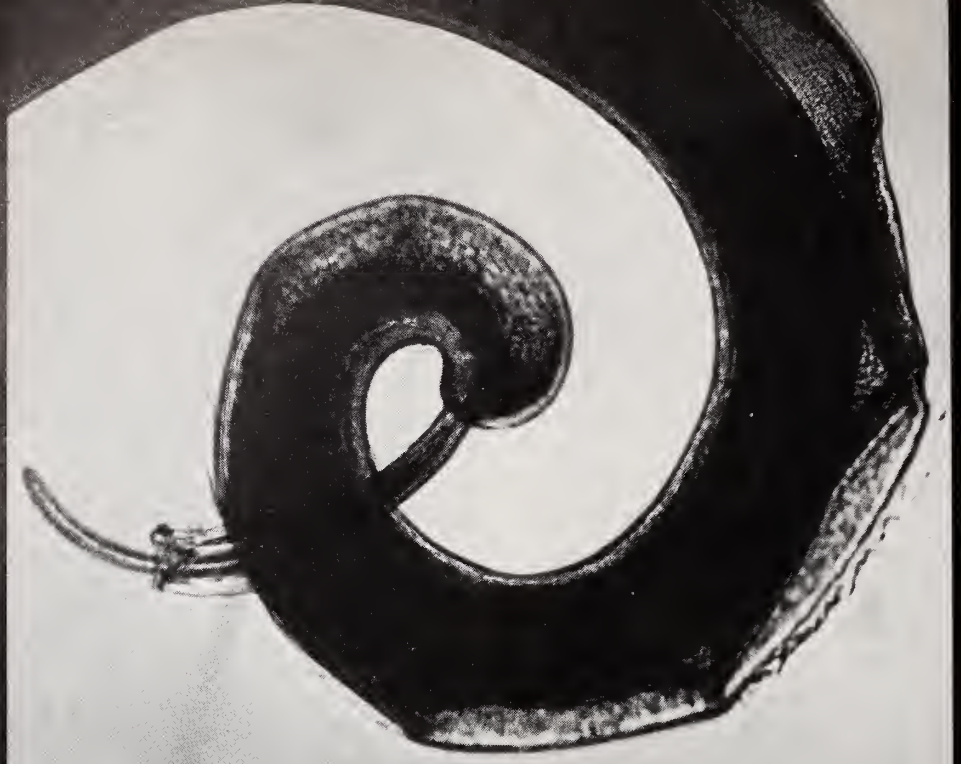
No group can presume to answer these questions for the nation. Policy makers assume certain answers as the basis for their recommendations. How well do they reflect public opinion? The questions have, in my view, not been put directly, clearly, or understandably, and so I do not think we have reliable answers. I do know that in the moment of illness, when the need for care is immediate and urgent, almost every person would put all these other things aside for considerate, compassionate, and competent care provided there is reasonable hope for recovery, and life is not being prolonged needlessly.

These are moral questions, turning on what as a society we believe to be good for humans as individuals and as communities. In short, what kind of society do we want to be? Economic as well as social and political issues are intermingled with medical-moral issues. Before we accept cost containment as the new slogan that will lead us to a well-ordered and responsive health and medical care system, we must examine these issues critically and as a society. The cynics will immediately protest that "society" cannot partake of such a critical inquiry. The only reply we can make is that if it does not, it cannot remain democratic. So important a matter as health and its impact on all other human services can be intelligently and justly disposed only if we are clear about our ends and purposes. Undeniably the physician, all other health professionals, and health care institutions have a crucial role in the equilibration of economics and medical morality. Their efforts in individual and personal medical transactions must be re-enforced by a context of policy decisions which also attempts to reach some equilibrium between the inherent tensions of the canons of morality and of economics.

This extended footnote to Tawney comes to a conclusion at this point. Economics must concern us, and it must provide the analyses of means and methods best suited to achieve the ends we define for our health care system. It cannot define those ends. Human purposes and values are too closely linked to what is good and what ought to be done, to the normative questions, and therefore must ultimately be decided through moral discourse.

References

1. Tawney RH: *Religion and the Rise of Capitalism.* Gloucester, Mass: Peter Smith, 1962.
2. Pellegrino ED: Toward a reconstruction of medical morality: the primacy of the act of profession and the fact of illness. J Med Phil; 1979; 4(1):32-56.
3. Pellegrino ED: *Ibid.*
4. Fox DM: *Economists and Health Care.* Prodist, NY: 1979, pp. 103.
5. Fleming D: Commentary on Fox and his commentators. In, *Economists and Health Care,* Prodist, NY: 1979, pp. 92-95.
6. Levine C: Ethics and cost containment. Hastings Center Report, Feb. 1979, pp. 10-13.
7. Sade RM: Medical care as a right: a refutation. N Engl J Med 1971; 285(23):1288-1292.
8. Fried C: cited by Levine C, *op. cit.*
9. Glaser RJ: cited by Levine C, *op. cit.*
10. Geigor HJ: cited by Levine C, *op. cit.*
11. Abrams HL, McNeil BJ: Medical implications of computerized tomography — 'Cat' scanning. N Engl J Med 1978; 298(5):255-261.
12. Ambrose J, Gooding MR, Ottley D: EMI scan in the management of head injuries. Lancet 1976; 1:847-848.
13. Gori GB, Richter BJ: Macroeconomics of disease prevention in the U.S. Sci 1978; 200(9):1124-1130.
14. Cullen DJ, Ferrara LC, Briggs BA, Walker P, Gilbert J: Survival, hospitalization charges and follow-up results in critically-ill patients. N Engl J Med 1976; 294(18):982-986.
15. Weinstein MC, Stason WB: Foundations of cost effectiveness analysis for health and medical practices. N Engl J Med 1977; 296(13):716-721.
16. Ginzberg E: cited by Levine C, *op. cit.*
17. Pellegrino ED: The anatomy of clinical judgments: some notes on right reason and right action. *Philosophy and Medicine,* Vol. 6, D. Reidel: Dordrecht, Netherlands, (Eds.) Engelhardt HT Jr, Spicker SF, Towers B, 1979, pp. 169-194.
18. Noren J, Frazer T, Altman I, De Lozier J: Ambulatory medical care: a comparison of internists and family general practitioners. N Engl J Med 1980; 302(1):11-16.
19. Delbanco TL, Myers KC, Segal EA: Paying the physician's fee: Blue Shield and the reasonable charge. N Engl J Med 1979; 301(24):1314-1320.
20. Newhouse JP, Phelps C, Schwartz WB: Policy options and the impact of national health insurance. N Engl J Med 1974; 290(24):1359.



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

© Janssen Pharmaceutica Inc. 1980

JPI-023



Broad-spectrum coverage in mixed helminthic infections

TABLETS
Vermox®
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

This discussion of illness among those actively involved in fighting in the "rebellion" also offers some interesting insight into the general state of Southern health at the time.

Mortality Rates of the U.S. Armies for the Year Ending June, 1862

J. J. WOODWARD, M.D.*

THE GENERAL MORTALITY rate of the armies of the United States during the first year of the rebellion was 67.6 per thousand of mean strength, including with deaths from disease those from wounds and injuries. The mortality from disease alone was 50.4 per thousand; that from wounds and injuries of every kind 17.2 per thousand.

In contrast with these results, it may be stated that the average annual mortality from disease alone in the United States army during 18 years of peace, was 24 per thousand. In the United States army during the Mexican war, it was 109.8 per thousand. In the British army during the Crimean war, 232 per thousand. In the British army, during the year 1859, 9 per thousand. It appears, therefore, that although the mortality of the army from disease during the first year of the present rebellion was far heavier than that of our own or of the British army in time of peace, it was much less than that of the armies engaged in the Mexican or Crimean wars.

Table 1 exhibits the monthly mortality rates of the army from July 1, 1861, to June 30, 1862. The armies have been consolidated for the purpose of comparison into three great divisions. The first consists of the troops operating on the Atlantic coast between the Appalachian range and the sea, and includes the army of the Potomac and the various coast expeditions. The annual mortality from disease alone among these troops was 33.4 per thousand of mean strength.

The second consists of the troops operating in the central basin of the continent, between the Appalachian and the Rocky Mountains, and includes Western Virginia, the armies under Generals Buell, Grant and Pope, the department of Missouri, with the scattered troops in Kansas, Nebraska, New Mexico, and the Northwest. The annual mortality from disease alone in this region was 82.19 per thousand.

TABLE 1 — Mortality rates of the armies of the United States during the year ending June 30, 1862, expressed in ratio per thousand of mean strength.

Atlantic	33.04
Central	82.19
Pacific	10.76

The third division consists of the troops on the Pacific slope, between the Rocky Mountains and the sea. It includes those serving in northern and southern California, Oregon, and Washington territory. The annual mortality rate was 10.76 per thousand.

It will thus be seen that on the Pacific slope, the mortality rate was three times less than on the Atlantic coast, while that of the latter region was twice and a half less than that of the troops serving in the central region.

The small amount of mortality on the Pacific coast is worthy of attention. The rate is hardly greater than that attributed by British and New England statisticians to young men of similar ages in private life. This exemption is in part due, there can be no doubt, to the fact that on the Pacific coast our troops found themselves under conditions much more closely approximating those of peace than of war. But the rate is so much less than has ever been known in the whole United States army in time of peace, that an idea of the superior healthfulness of the Pacific coast is at once suggested. The greater mortality of the central region, as compared with the Atlantic coast,

* Dr. Woodward practiced surgery at the time this article was written. Published here are extracts from his report to the Surgeon General of the United States. It originally appeared in the *Confederate States Medical and Surgical Journal* in January 1864. Courtesy of the New York Academy of Medicine Library.

would appear to hold a close relationship to the great prevalence of malarious disease in the valleys of the Mississippi and its tributaries, which is indicated by Tables 3, 4, and 5 which show the monthly rates of camp fever, intermittent fever, and diarrhea.

The three great regions above contrasted differ not only in their annual mortality rate, but the relations of mortality to season are also quite different.

Thus, on the Atlantic coast, the mortality, after falling off in September, steadily increased during October, November, and December, diminished through January and February, and then steadily increased again through March, April, May, and June.

In the central region the mortality rates became gradually greater from July, 1861, to March, 1862, diminished in April, increased again in May, and diminished in June.

On the Pacific coast a much more fluctuating course was pursued, and quite unlike either of the others, as will be shown in Table 1.

General Prevalence of Disease

TABLE 2 — Sickness rates of the armies of the United States during the year ending June 30, 1862, expressed in ratio per thousand of mean strength.

Atlantic	239.75
Central	232.83
Pacific	193.51

The difference between the three regions above contrasted is not so conspicuous in the general sickness rates as in the mortality, yet the whole number of sick in the central region was greater than on the Atlantic coast, and in this again greater than on the Pacific. In the first, the number taken on sick report during the year was 3,364.14 per thousand of mean strength; in the second, 2,748.83, and in the third, 2,586.60. It will thus be seen that in each of these regions a large proportion of the troops must have been sick several times during the year.

Table 2 exhibits the ratio of "taken sick" for each of the three regions. It does not indicate the "constant sickness rate," but the total number taken on sick report during the month. The monthly fluctuations exhibited by this table are, of course, much less instructive than those of individual diseases; they serve, however, to indicate a gradual improvement in the sanitary conditions of the army during the war.

It would be exceedingly interesting were it possible to present a table representing the "constant sickness rates" for the same period; but the imperfect data in the Surgeon-General's office, for the first year of the war, do not afford the means for computing such a table in a reliable manner.

This makes the percentage for the year, 2,748.83 on the Atlantic border; 3,368.14 in the Central region, and 2,586.60 on the Pacific coast.

Camp Fever

TABLE 3 — Rates of camp fever in the armies of the United States during the year ending June 30, 1862, expressed in ratio per thousand of mean strength.

Atlantic	27.07
Central	27.64
Pacific	1.78

Under the head of camp fever, all the cases reported to the Surgeon-General's office, as typhus, typhoid, common continued, and remittent fevers, are here concluded. Of these several categories, it may well be doubted how far the cases reported as typhus were really of that character. From the details furnished by sanitary reports, it appears probable that, with perhaps rare exceptions, what was regarded as typhus was in fact of a very different nature; severe typhoid fever, with cerebral complications, and congestive intermittents in scorbutic constitutions being shown, in some cases at least, to have been regarded as typhus. This error was not, however, very widely diffused, the whole number of cases reported as typhus amounting to but a few hundred. As for the cases reported as common continued fever, the vast majority appear to have been different only in degree of severity from those reported as typhoid or remittent. Moreover, while a certain amount of uncomplicated enteric and remittent fever certainly did occur, especially at the commencement of the war, the vast majority of the camp fevers of the army were of a mixed character, exhibiting undoubted enteric phenomena, variously combined with the periodicity and other peculiarities of malarial disease, and still further modified by the tendency of incipient scurvy, which is the ordinary concomitant of camp diet. To indicate this mixed nature, the term typhomalarial fever, which I had the honor to suggest to the department in June, 1862, appears appropriate, and, at the present time, is coming into very general use.

A correct understanding of the nature of these fevers is of the utmost importance, as they play a conspicuous part in the mortality of our armies. During the year under consideration 44.5 per cent of all the deaths from disease were due to camp fevers.

An examination of Table 3 shows that the frequency and mortality of camp fever differs considerably in the three great regions. On the Atlantic border, the annual ratio of cases was 238.99 per thousand of mean strength, and the ratio of deaths to cases was 71.9 per thousand, or one death to every 13.9 cases. In the central region, the annual ratio of cases was 319.94 per thousand, and the ratio of deaths 101.8 per thousand cases, or one in 9.8. On the Pacific coast, the annual ratio of cases was only 60.95 per thousand, and the ratio of deaths to cases 45.2, or one in 22.1. The severity of camp fever in

these several regions is thus shown to differ as considerably as their frequency.

An inspection of the table at once exhibits the autumnal character of the disease. On the Atlantic coast, the monthly number of attacks steadily increased until November, 1861, then as steadily diminished until March, 1862; after which they once more increased in frequency. In the central region, the maximum was attained in September, 1861, followed by a gradual diminution till March, and a subsequent increase as on the Atlantic coast. On the Pacific coast, although there is less regularity in the fluctuates, [sic] it will be observed that October was the maximum month. The most superficial observer cannot fail to be struck with the similarity between these three waves and those of the intermittent fevers, of whose malarial nature there is no doubt, and which are illustrated in the next table.

This makes the percentage for the year 238.99 on the Atlantic border; 319.91 in the Central region, and 60.95 on the Pacific coast.

Intermittent Fever

TABLE 4 — Rates of intermittent fevers in the armies of the United States during the year ending June 30, 1862, expressed in ratio per thousand of mean strength.

Atlantic	16.88
Central	26.02
Pacific	12.46

Intermittent fever, although a very frequent affection, has not been the cause of any great mortality. On the Atlantic border, the annual ratio of cases was 195.94 per thousand of mean strength, the rate of deaths to cases 6.0 per thousand, or one to 165.9. In the central region the annual ratio was 375.34, the deaths 5.9 per thousand cases, or one to 170.0. On the Pacific coast the annual ratio was 151.68 per thousand of mean strength and no deaths. The distinctly autumnal character of the disease is well illustrated in Table 4.

This makes the percentage for the year 195.94 in the Atlantic border; 375.34 in the Central region; and 151.68 on the Pacific coast.

Diarrhoea and Dysentery

TABLE 5 — Rates of diarrhoea and dysentery in the armies of the United States during the year ending June 30, 1862, expressed in ratio per thousand of mean strength.

Atlantic	87.06
Central	83.02
Pacific	30.25

Diarrhoea and dysentery caused about one-fourth of all the sickness reported. On the Atlantic border, more than half the army suffered, and in the Central region the number of cases almost equalled the mean strength. Although not nearly so fatal as camp fever, affections [sic] of this class were an important cause of the mortality of our army. In the chronic cases, though most generally called diarrhoea, and not dysentery, the colon was the seat of the chief lesion. The most characteristic postmortem appearance was a thickened, softened condition of the mucous membrane, with pigment deposit and enlargement of the solitary follicles, frequently terminating in ulceration, the ulcers being sometimes punctiform, sometimes extensive, and irregular. In this condition the small intestine frequently participated, more or less, but often presented nothing abnormal.

It appears from Table 5 that the annual ratio of diarrhoea and dysentery on the Atlantic coast was 646.01 cases per thousand of mean strength.

In the Central region, it was 994.77 per thousand, and on the Pacific coast 319.64. The relative mortality was, in the Atlantic region, 21 deaths per thousand cases, or one in 483; in the Central, 9.6 per thousand, or one in 103.8; on the Pacific, 0.9 per thousand, or one in 1,159.

This makes the percentage for the year 646.01 on the Atlantic border; 994.77 in the Central region; and 319.61 on the Pacific coast.

Catarrhal Affections

TABLE 6 — Rate of catarrhal affections in the armies of the United States during the year ending June 30, 1862, expressed in the ratio per thousand of mean strength.

Atlantic	11.33
Central	11.71
Pacific	17.25

Catarrhal affections [sic] of every class were exceedingly common, attacking nearly one-half the forces in the field. The relative frequency in the three regions of the country appears to have been about the same. On the Atlantic border, 456.47 per thousand of mean strength. In the Central region, 427.2 per thousand, and on the Pacific slope 497.61. In all, the frequency of these affections increased greatly during the winter, and diminished during the warmer months. The maximum month being January for the Atlantic and Central, and February for the Pacific region. A large proportion of the severer catarrhal cases occurred as sequellae to camp measles. The vast majority of the simple catarrhal cases terminated in recovery, the deaths being one to every 1,127.8 cases on the Atlantic coast; one to every 560.0 cases in the Central region; and no deaths occurring from this cause on the Pacific region. A certain number of these catarrhal cases, however, terminated in pneumonia, and thus a part, at least, of the mortality of

Continued on page 243

NEW
PRODUCT
INFORMATION

clinical significance



of constipation

ROHER
WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Constipation acute or chronic

Constipation may be caused by conditions affecting the filling and emptying of the rectum.

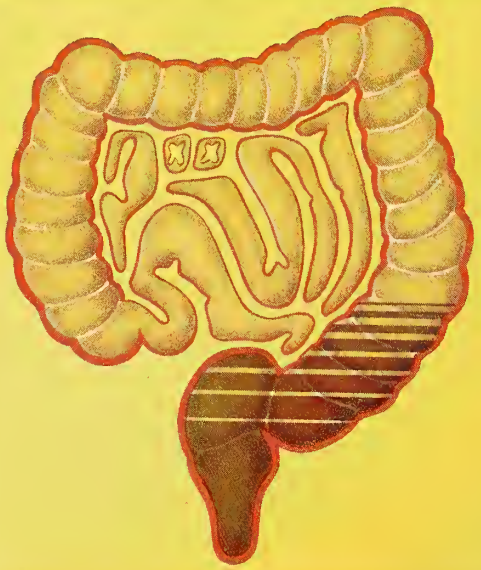
Inadequate filling

Interference in propulsive contractions

Impairment of smooth muscle contractility

Obstruction of the lumen





Inadequate emptying

Interference in the stimulation of the defecation reflex

An additional complication

Self treatment—use and abuse of laxatives

Treatment of underlying disorders is critical...
Relief of constipation is essential

Perdiem™...distinctive!

A unique blend of natural vegetable derivatives For comfortable and safe relief of constipation

Psyllium

- A natural source of hydrophillic colloids
- Strengthens stimulus to defecate by increasing indigestible residue
- Helps produce soft, hydroted, well formed stool



Senna

- Produces mild peristoltic stimulotion
- Helps propel bulk through colon



A unique granular formulation

- No mixing or chewing
- Gronules ore placed in mouth ond swallowed with full gloss of beveroge
- Helps break cothortic hobituotion
- Helps estoblish normol defecotory reflexes ond regular bowel rhythm

John Moerz, M.D.
Medicol Director
W. H. Rorer, Inc.
Fort Woshington, PA 19034

Deor Dr. Moerz:

Yes, I would like to receive o supply of Perdiem™ starter somples for my patients.

Dr. _____

Address _____

City _____

State _____

Zip _____

Specialty _____

SJ-312

New Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours): reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules; 100 gram (3.5 oz.) and 250 gram (8.8 oz.) canisters.



Made in West Germany

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 29 Ft. Washington, PA.

POSTAGE WILL BE PAID BY ADDRESSEE

William H. Rorer, Inc.
500 Virginia Drive
Ft. Washington, PA. 19034

ROHER

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Attn: Marketing Services

Decompression laminectomy for nerve root irritation followed by lateral type fusion offer the best chance for permanent relief of pain for patients with this condition.

Surgical Treatment of Spondylolisthesis

H. DALE RICHARDSON, M.D., and C. WILLIAM BROWN, M.D., *Atlanta**

Abstract

This paper presents an evaluation of the surgical treatment of 21 patients with spondylolisthesis between 1976 and 1979. All patients were treated by decompression laminectomy and lateral fusion for stabilization.

Fifteen of the 21 patients were receiving Workmen's Compensation, and surgical results for 13 of them were good to excellent. Results of surgical treatment for the six private patients were also good to excellent.

It is the opinion of the authors that decompression laminectomy for nerve root irritation followed by lateral type fusion offer the best overall chance for permanent relief of pain and return to gainful employment.

Spondylolisthesis is a condition, usually involving the lumbar spine, in which a vertebra slips forward onto the adjacent one[1] as a result of a defect in the pars interarticularis.[2] The defect in the pars alone, without slippage, is known as spondylolysis.[1]

Approximately 5.8% of the white population in the United States has this defect.[1, 3] The occurrence varies widely with race. It has been reported as being about 2% or less in the black population and as high as 60% in certain Eskimo tribes.[1, 3]

* Dr. Richardson is Attending Neurosurgeon, Piedmont Hospital, and Chief of Neurosurgery, Georgia Baptist Hospital. His address is 105 Collier Rd., NW, Ste. 3060, Atlanta, GA 30309. Dr. Brown is Attending Orthopedist, Georgia Baptist Hospital, Crawford Long Hospital, and is Chief of Orthopedics, Doctors Memorial Hospital. His address is 478 Peachtree St., NE, Ste. 106-A, Atlanta, GA 30308.

While spondylolisthesis has been reported in patients as young as 3½ months of age, this is quite rare. There is, however, a considerable increase in the incidence of spondylolisthesis around the age of 5 to 6 years.[1]

Spondylolisthesis used to be considered of congenital origin but is generally thought now to be caused by fatigue fractures of the pars interarticularis[1, 4, 5] (Figures 1 and 2). These fractures can develop quite early in life and seem to have a strong hereditary association.[1] Cyron, Hutton, and Troup were able to reproduce experimentally a neural arch fracture which appears to be essentially the same as that seen in spondylolysis.[6]

All the patients discussed in this paper are adults. Three are women, 18 are men. None had slippage greater than the 1st degree or approximately 30% of the width of the vertebral body (Figure 3). Severe slippage of L_5-S_1 is generally encountered in younger patients, with increasing neurologic deficit, pain, and severe lordosis. This usually becomes apparent at an earlier age than that of our patients,[7] who were all of working age and relatively free of symptoms prior to the onset of those symptoms which caused their incapacitation.

Results of Surgery

For purposes of evaluation, the results have been divided into the following categories (Table 1):

1. Very good to excellent. These patients have no pain with full activity and employment.
2. Satisfactory. These patients have minimal pain which does not incapacitate them. They are working or being retrained for lighter work.
3. Fair. Residual pain is present but improved over



Figure 1 — Grade I spondylolisthesis, with L_5 slipped forward on the sacrum.



Figure 2 — Defect in the pars interarticularis permits anterior slippage.

preoperative condition. Patient is not working.

4. Poor. Patient is not working and has only minor improvement.
5. Failure. No improvement. Not working.

Nineteen of the 21 patients are either working or being retrained through vocational rehabilitation, representing a success rate of approximately 90%. The other two patients, while improved over their preoperative condition, are not working, and their prognosis is regarded as limited or poor.

TABLE 1 — Results of Surgical Treatment of Patients with Spondylolisthesis, by Type of Patient

Surgical Results	*Private Patients*	*Patients Receiving Workmen's Compensation*
Very good to excellent	5	8
Good	1	5
Fair	0	0
Poor	0	2
Failure	0	0
Total	6	15

Discussion

Surgical treatment of spondylolisthesis has been varied. Du Toit reported treatment by anterior fusion.[4] The Gill procedure is a common one and entails the complete excision of the defect of the arch of the lamina,[8] thereby compressing the nerve roots and dural sac. The problem with the Gill procedure is that further slippage is fairly common since nothing is done for stabilization.[9] Buck has reported a series of patients in which direct repair of the defect in spondylolisthesis has been done.[5] Results are no better than laminectomy and fusion. In our series, we felt that the Gill procedure alone was not indicated, since most of the patients were active and working. It is felt that the Gill procedure is indicated for decompression of the nerve roots, since the presence of the loose element and fibrous union of the arch is a significant irritant factor to the adjacent nerve roots as they exit. Combined total laminectomy and fusion has produced better overall results than those reported with just the Gill procedure. All of our patients were treated with a combination of the Gill procedure and lateral fusion. For L_5-S_1 spondylolisthesis, we used a two-level fusion, as degenerative disc disease or herniation of the disc at L_5-S_1 is commonly found with spondylolisthesis of L_5-S_1. The two-level fusion tends to prevent recurrent problems occurring at L_{4-5} (Figure 4).

Three of our patients had spondylolisthesis at a level other than L_5-S_1. One had an L_{3-4} spondylolisthesis without slippage, another had an L_{4-5} degenerative spondylolisthesis, and two had an L_{4-5} spondylolysis.

Fifteen out of the 21 patients were receiving Workmen's Compensation during their illness. Most of their jobs required some bending, stooping, or lifting, thus causing considerable stress to the lower back. For this reason, it was felt that with a combined

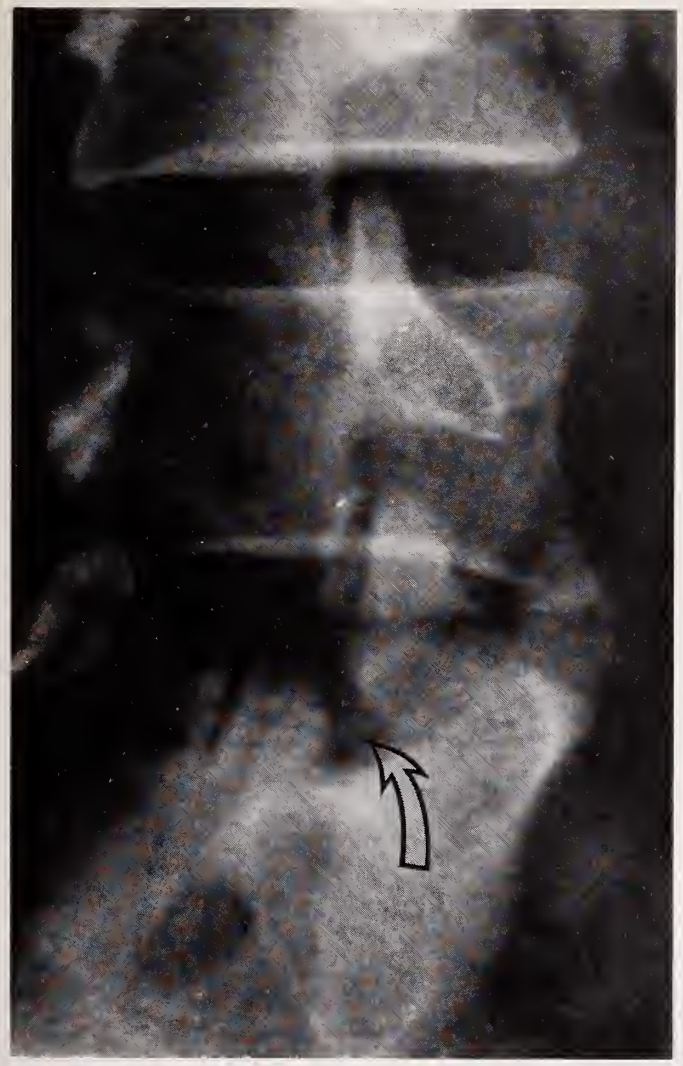


Figure 3 — Oblique X-ray of lumbar spine, with defect in pars interarticularis.

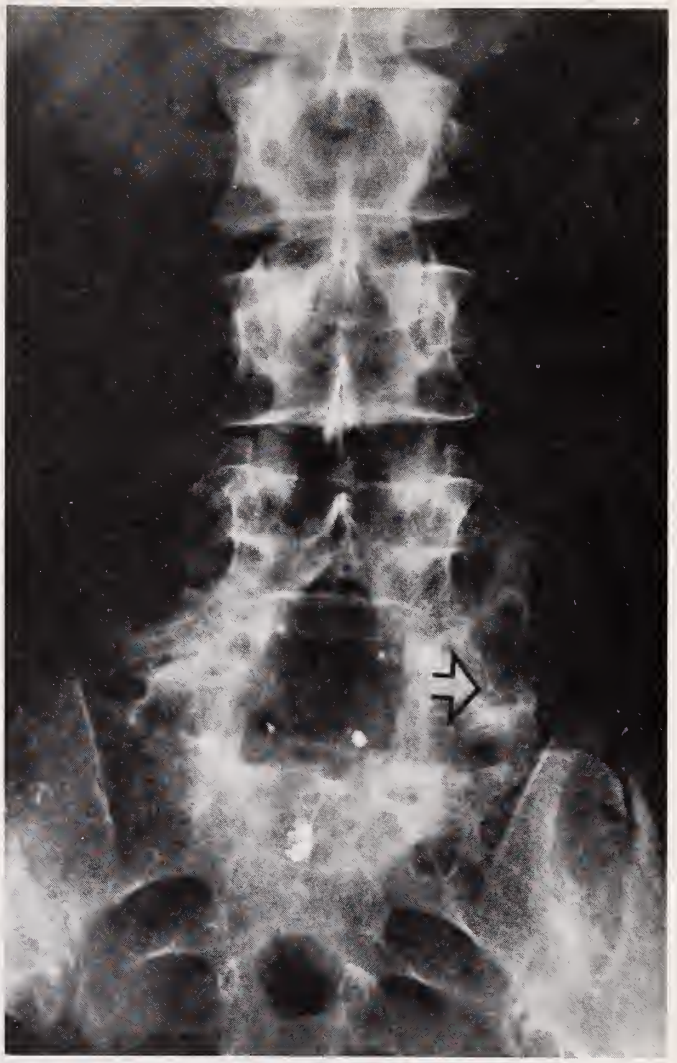


Figure 4 — PA view of bilateral posterolateral fusion from L_4 to S_1. The lamina of L_5 has been totally removed.

procedure of total laminectomy and fusion, decompression of the nerve roots and stabilization of the unstable area of the spine was accomplished, and further slippage was prevented. Once a patient has an adequate fusion, he does not require further surgical intervention.

Summary

A discussion of 21 patients with spondylolisthesis was presented and consideration for surgical treatment outlined. Wide decompression by laminectomy and decompression of the nerve roots, followed by posterolateral fusion of the lowest two levels, gave satisfactory results in 90% of these patients.

References

1. Wiltse LL, Widell EH, Jackson DW. Fatigue fracture: the basic lesion in isthmic spondylolisthesis. J Bone Joint Surg 1975;57:17-22.

2. Dandy DJ, Shannon MJ. Lumbosacral subluxation (Group I spondylolisthesis). J Bone Joint Surg 1971;53:578-594.

3. Henderson ED. Results of the surgical treatment of spondylolisthesis. J Bone Joint Surg 1966; 48:619-642.

4. Du Toit JG. Spondylolisthesis and its treatment by anterior fusion. J Bone Joint Surg 1971; 53:563.

5. Buck JE. Direct repair of the defect in spondylolisthesis. J Bone Joint Surg 1970; 52:432-437.

6. Cyron BM, Hutton WC, Troup JDG. Spondylolytic fractures. J Bone Joint Surg 1976; 58:462-466.

7. Barash HL, Galante JO, Lambert CN, Ray RD. Spondylolisthesis and tight hamstrings. J Bone Joint Surg 1970; 52:1319-1328.

8. Davis IS, Bailey RW. Spondylolisthesis — long-term follow-up study of treatment with total laminectomy. J Bone Joint Surg 1971; 53:1025.

9. Amuso SJ, Neff RS, Coulson DB, Laing PG. The surgical treatment of spondylolisthesis by posterior element resection. J Bone Joint Surg 1970; 52:529-536.

10. Alvik I. Surgical treatment of spondylolisthesis. J Bone Joint Surg 1968; 50:223-224.

11. Grantham SA, Imbriglia JE. Double level spondylolysis and transitional vertebra. J Bone Joint Surg 1975; 57:713-714.

12. Rosenberg N. Degenerative spondylolisthesis. J Bone Joint Surg 1975; 57:467-474.

The author describes his experience crewing a yacht from the Canary Islands to Barbados.

What Do You Do for Encores?

JOHN I. DICKINSON, M.D., *Rome**



Formerly owned by the Prince of Monaco, the *Cecelia* safely carried her crew of nine on an exhilarating voyage across the Atlantic Ocean.

* Dr. Dickinson is a general surgeon. His address is 310 W. Sixth St., Rome, GA 30161.

It was a cold, rainy night in autumn. I had packed away my fishing gear for the season and resigned myself to a period of deprivation of the outdoors. Good days for golf and tennis were becoming few and far between, and the trip to Snowmass, Colorado, in March seemed light years away. While bemoaning my fate, I encountered an old friend who offered me an escape from winter's confinement and doldrums. If I could arrange to take off from work for the month of January, I had an opportunity to participate in an adventure of a lifetime: crewing a yacht from the Canary Islands to Barbados.

A mutual friend from Dalton, Georgia, had purchased an 88-foot yacht, the *Cecelia,* from the Prince of Monaco and was proposing to sail it from the Canary Islands to Barbados. The crew was to include seven amateur and two professional sailors. In return for this all-expense-paid vacation in the sun, I was to be responsible for any medical needs that might occur. That I had no significant experience with sailing was of no concern to them, so I didn't let it bother me either. After repairing and provisioning the yacht and practicing a few basic sailing techniques, we set sail, following approximately the course that Columbus took. We hoped to avoid using our auxilliary engine at all and to reach our destination in 3 weeks.

During the trip, I kept a daily log, which I have reproduced here. I believe it tells the story of our trip better than a simple narrative could.

Jan. 10: Worked all day on the ship, which was in poor shape, but nothing major wrong. Stowed unbelievable amounts of food.

Jan. 11: Had planned shakedown but motor out. Worked on boat, learned some navigation. Facing problem of who to take. Tex and Tina? Will be interesting to see how this is decided. Right now, Tina has the bunk opposite me; she talks in her sleep. Tex sleeps nude. Peter sleeps hard, and Carlos must sleep elsewhere, probably with Ursula who plans to fly home tomorrow. Food storage is a real problem. We went through emergency procedures and watch schedules. Checked medical kit and practiced some navigation. Hope to sail tomorrow.

Jan. 12: Early breakfast, Tina can't find her skirt. Has a black slip on. She and Tex going on *Ocean Spirit,* also to Barbados — a great solution to our problem. Ursula left today. Worked on engine, came to a standstill when everyone admitted defeat. Had lots of fun making and doing things — hull repair, canvas made. (A masterpiece!) Late afternoon, we decided to go ahead even if engine not running but mechanic from Volvo place came and had no trouble with it. Definitely sail tomorrow — 11:30 AM?

Jan. 13: Beautiful day! Preparing to sail unless bad weather sets in. Dropped light reflector overboard but made another out of beer can by removing ends and using scissors. Sails readied, anchor lines brought in, deck swabbed, everything stowed, and declared shipshape. Finally left harbor under power about 4 PM. A fantastic, deeply moving experience. People lined the dock, waving and taking pictures. Small boats followed us out. Sails were then raised, and we were off. Sea was rough. Feared some might be sick, so gave them Dramamine. We slept on deck. When sun went down, it got quite cool. The wind came up, and we really started sailing. Only trouble was, terribly rough seas — wildest night I ever spent. A trip forward for an onion was one of the scariest events of my life. First watch, 2200-0200, was really something. I felt sick, scared, and yet tremendously elated.

Jan. 14: Slept fitfully for 7 hours. Ate breakfast and took morning watch. Sea still rough but relatively uneventful. Last sight of land 1430. We will not see it again for 3 weeks. Because the land is stealing wind, we will motor tonight and begin our sail in AM. Beautiful watch with some clouds and moon. Had a great dinner on gimbal table and lively political



The author at the helm of an adventure, where he spent about a third of his time and loved it.



Aboard the *Cecelia,* a view toward the stern from midship.

discussion with H.H. — he is a wine maker and pilot and impresses me more every day.

Jan. 15: All hands called at 0800. Scared me to death till I remembered that we had planned to raise sails! This went fairly smoothly. They may stay up a long time. I took morning watch after breakfast. I'd sure like a shower, but not on a pitching deck in cold sea water — not yet, that is! Things are settling down. We are getting used to the motion, so no more seasickness. I am still scared on deck. Our navigators Harvey and Carlos are doing very well. We are not making maximum speed but doing satisfactorily. Entered new time zone. Noon meeting with crew a farce. Night watch after a good nap; not too bad, but sea still very rough.

Jan 16: Fitful sleep but after a good nap, I feel good this AM. I fixed breakfast — Coffee, OJ, and cereal with bananas. Doesn't sound like much till you do it standing on your head! Made my bed up neatly which may help me sleep. I'm worried that our fresh food is not getting used up and will spoil. At crew meeting, we had a lively discussion about religion, and I appear to be the only Christian by my definition. They read parts of *The Prophet,* and when I said I thought he would go to hell, they were appalled. No converts today. Long nap, Bible reading, a great curry dinner.

Jan. 17: Continued rough sailing — took several waves aboard. No sightings today. Caught several flying fish. Weather becoming milder. Good political discussion today. Navigation seems to be going great. We cleared the Cape Verde Islands, now running 220 degrees, headed for warmer weather. Using up perishables. Daily sick call offered but no takers. Now becoming part of the sea, accepting petty problems, and adjusting sleep habits. Will take shower tomorrow regardless of weather!

Jan. 18: Freighter sighted at dawn; we made radio contact and our position was confirmed as plotted. They will contact Miami Coast Guard and give our position and plan. Not making much speed, need more sail. Bananas in forward head getting ripe and falling everywhere. Showered and shampooed today, felt good.

Jan. 19: Don't feel well today. Raised mainsail with double reef which should help increase speed to 7 knots. Read a book all day. Sighted a ship on night watch.

Jan. 20: Mom's birthday. Mighty homesick. Passed 1/3 point today. Had a picnic on deck with sardines, cheese, beer, crackers, and lots of tabasco (pint bottles). Great! Defrosting refrigerator was a real job. Settling into routines now, and though still rough, I am able to do everything but write. Ricky (Harvey's 75-year-old father) is a fabulous reciter of poetry and keeps us entertained. Navigation going well. I am not getting too deeply into it. Had a great talk with Harvey and Willard about management problems. Last night, projected arrival Barbados now on Feb. 3 unless we pick up a lot

of speed. Reading Bible *(Luke)* most of my 2 hours off the helm.

Jan. 21: Awakened to sound of starting motor and raising mainsail. Continued south till 15° latitude, then will turn and run west. It's getting much warmer. Food excellent. No illness or injuries other than scrapes and bruises. Cleaned out refrigerator.

Jan. 22: Took reef out of mainsail and raised jib topsail. Speed increased to 7 knots average. Took shower and did laundry today. Happy hour will now be at midday so everyone can participate, reasoning being that everyone is on deck at that time anyway, and if helmsman gets drunk, there will always be someone to take over. Slept most of afternoon and also after a great lamb (or goat?) dinner. Watch began at midnight; it's very warm tonight. Have almost finished *John;* did finish *Winds of War*. Passed halfway point.

Jan. 23: What a day! At about 1300, the "Halfway Ceremony" began with a dousing in the ocean (from the bosun's chair while doing 7 knots), awarding medals and crowns, a songfest, and more rum punch than the helmsman should have had. Nothing else occurred, 'cause we spent the rest of the day asleep.

Jan. 24: On watch, all was quiet till just before the end when we had a ship sighting which would not respond to our radio. (We are in the U.S. to Cape shipping lanes now.) The ship passed on to starboard, and I went to bed only to be aroused in an hour by an all-hands call for another ship which came awfully close. It was a German ship, and apparently oblivious to the fact that it had scared us. After some maneuvering, all was calm again. Weather was a little cloudy, with spitting rain all evening, but today has been beautiful. We are beginning to get on each other's nerves a bit, but considering our close quarters, I think we are doing well. Crew remains healthy. Today Peter went aloft to fix some of the rigging — brave soul.

Jan. 25: Nelson saw a green flare on the port beam, and we spent all night searching the area looking for its source or other signs and found none. We took extra watches so got little sleep. Now problem is to decide when to give up and move on. Harvey made that decision, and we resumed our course. Spent evening catching up on sleep. Watch uneventful.

Jan. 26: Made my first pancakes from scratch — a double batch with honey and then more. They were good! Funny how they were all oval, since we were tossing from side to side! We even found some country ham. Am now on watch, having spent an hour on the helm. Having trouble getting Carlos to take his turn on the wheel. Am getting tired of his shirking his duties. Harvey has let Don and me take over breakfast and lunch preparation. Peter spends an hour fixing supper but stands no watch. He does the mechanical work and helps raise the sail in addition to 10-12 hours in the sack. He apparently has Harvey over a barrel, and is taking advantage of it. No meeting today.

Jan. 28: Washed clothes and then got drenched twice! Will wash again tomorrow. Took day off from cooking — nobody ate breakfast, and we had only soup for lunch. Had our first ice since sailing. We have a freezer but couldn't keep water in trays. The solution was freezing water in plastic bottles. While celebrating, we got drenched!

Jan. 29: We have had no sightings in 5 days. Utter isolation. Sea remains rough, but we are sleeping better. Plan to arrive in Barbados in approximately 3 days.

Jan. 31: Overcast, wind has died. Porpoise and albacore schools played around boat, but fishing non-productive. Very slow speed all day. Drew lots of landfall 350 miles away. Don and I made Salisbury steaks with mushrooms and more onions than an army could eat — we thought. Turns out we needed more! One ship sighted on parallel course. First sighting in 6 days. Temperature 76° at night, and 80° in daytime. I don't particularly like Paul's letters.

Feb. 1: Everyone is looking forward to getting into calm water or onto dry land. I bet it will seem odd at first. Beautiful day today, somewhat lazy, but made good time.

Feb. 2: Still have another day to go. We have made bets as to arrival times. Having water problems and can only use water on deck. Generator has gone out completely, but we have one on the main motor. Tanker passed and verified our position. Will arrive Barbados tomorrow evening.

Feb. 3: Spent all day looking for land — finally Nelson sighted it at 1430. We came in under sail, I was at the helm. We must have made quite a sight — the beaches and other boats were lined with spectators. We dropped anchor, raised the yellow flag, contacted customs by radio, and awaited quarantine clearance. Despite quarantine, Tex and Tina came

on board immediately, and we had one hellava party — champagne, then whiskey, no supper, so we all fell into bed exhausted.

Feb. 4: What a mess this boat is! Spent all morning cleaning and storing. Customs officials came around noon and give us clearance. We rented a sunfish sailing boat and went exploring, then ashore for a drink.

Our adventure, viewed medically, was a complete flop — no one got sick or was injured. I came prepared to stop bleeding, suture wounds, and splint fractures, and stocked analgesics and antibiotics. Failures like these I can live with happily.

As an experience of a lifetime, it was a complete success. The open sea, both day and night, is fantastically and indescribably beautiful. The action of a well-built ship in rough water is a study of grace and design. Although major things became insignificant, and minor problems consumed large amounts of time and energy, they were challenging and different from anything I had ever encountered before. The action of the ship added an entirely new dimension to my life. I had to lash myself in my bunk, and on deck at night I wore safety gear at all times. Cooking was a major task, and using the "head" was not simple, to say the least.

I have sailed once in the Caribbean since this trip and really enjoyed it. But it wasn't the same. What do you do for an encore, after experiencing the ultimate sailing adventure?

Keogh— to prepare for the years ahead.

Keogh at Fulton Federal is a retirement plan for the self-employed. It allows you to contribute 15% of your earned income, up to $7500 per year, and defer taxes on your deposits, until you retire.

If you already have a Keogh Account, please note that contributions can be made as late as the tax filing deadline, including extensions.

To find out more, call Fulton Federal's Retirement Plan Counselors at (404) 586-7031. Keogh— it's the way to prepare for the years ahead, starting today.

EQUAL HOUSING LENDER

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 Atlanta, Georgia 30301 404-586-7283

SAILING YACHTS
BROKERAGE & SALES

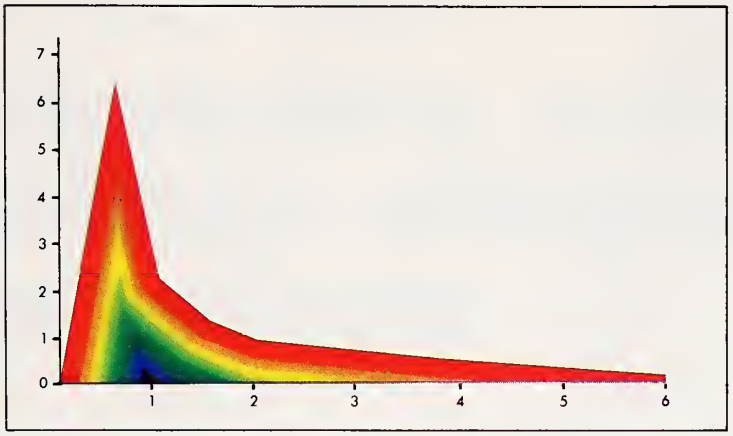
SAILING SCHOOL
(COASTAL GEORGIA)

CHARTERS

BLACKBEARD YACHTS LTD.
3483 PEACHTREE ROAD N.E. ATLANTA, GEORGIA 30326

J. S. JURSKIS
PRESIDENT
404-233-9463

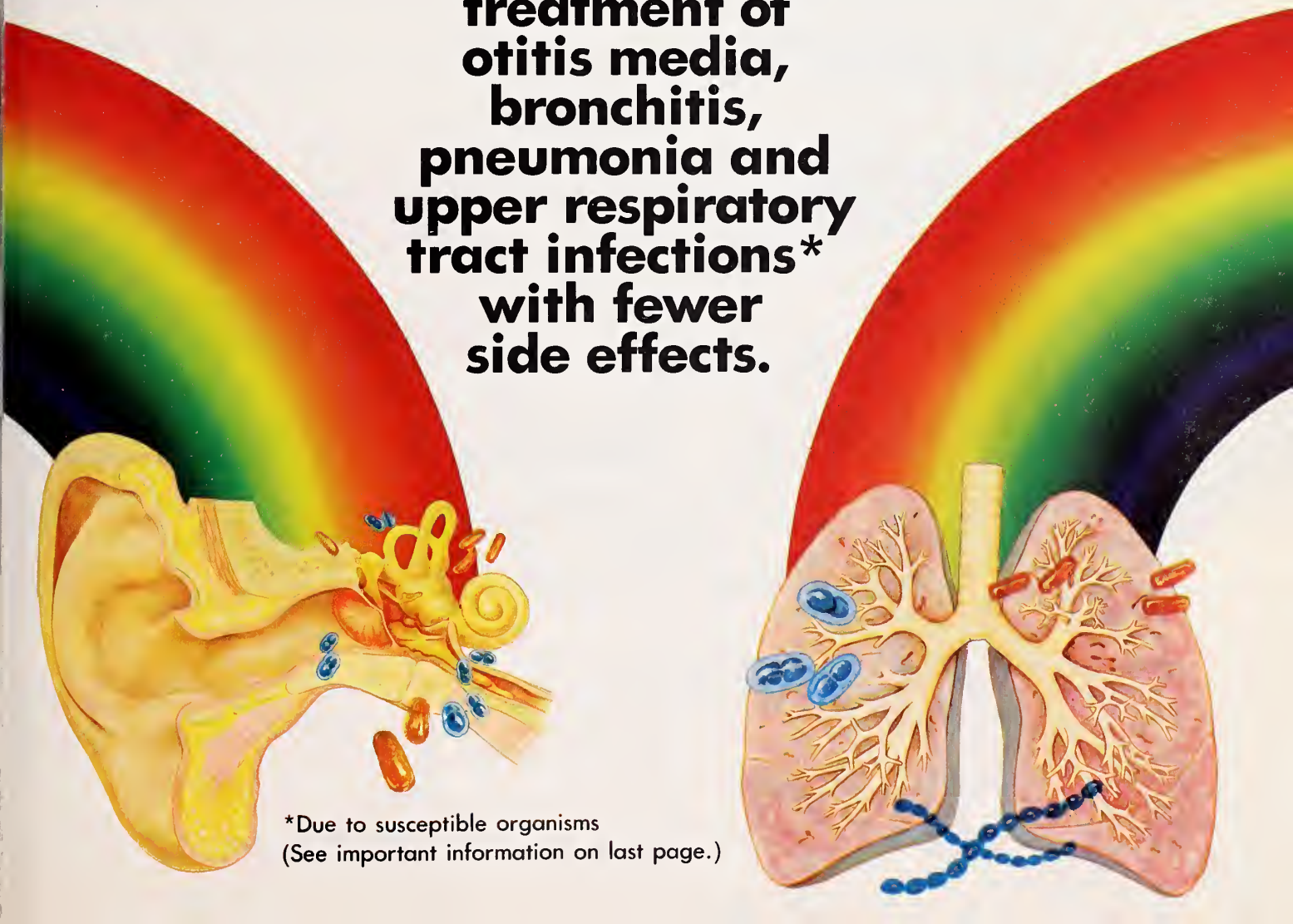
more than just spectrum



New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of otitis media, bronchitis, pneumonia and upper respiratory tract infections* with fewer side effects.



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN®
(cyclacillin) Tablets/ Suspension

efficacy with fewer side
ampicillin confirmed in
studies of 2,581

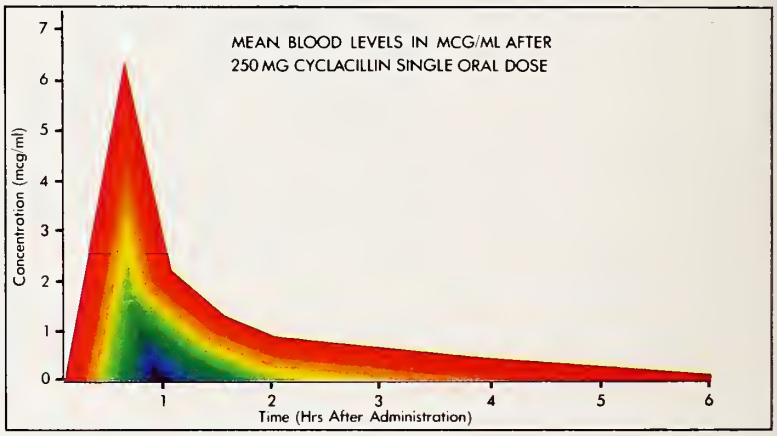
Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin





Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
S. pneumoniae	96	82
	95	
H. influenzae	88	96
	85	

% Clinical Response
% Bacterial Eradication

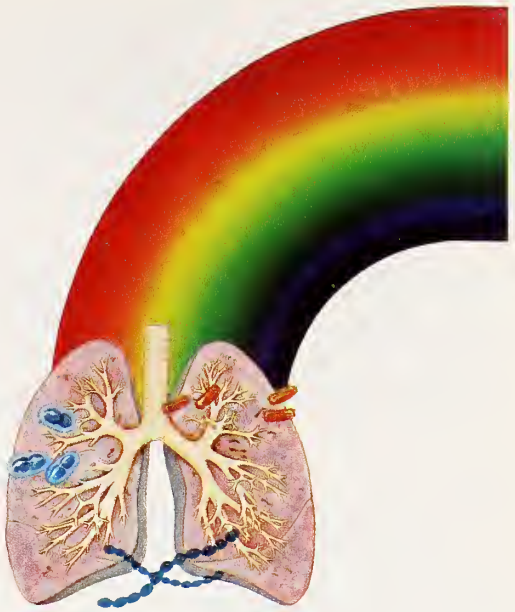
more than just spectrum in otitis media

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

Copyright © 1979, Wyeth Laboratories. All rights reserved.

effects than double-blind patients*



ewer side effects with CYCLAPEN® in louble-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant (P <0.001)	

In bronchitis, pneumonia and upper respiratory tract infections†

High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100	73
	95	
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100	44
	86	
% Clinical Response % Bacterial Eradication		

CYCLAPEN® (cyclacillin) effective for otitis media† in children

- Excellent clinical results in eliminating the two most common causative organisms in otitis media
- Significantly lower incidence of diarrhea and skin rash in children treated with CYCLAPEN® Suspension

	diarrhea	rash
CYCLAPEN	9.1%	2.1%
ampicillin	19.2%	5.8%
	P < 0.001	P < 0.03

more than just spectrum

CYCLAPEN®

(cyclacillin) Tablets/ Suspension

1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.

(See important information on next page.)

Wyeth Laboratories
Philadelphia, Pa. 19101

New from Wyeth Laboratories

CYCLAPEN®

(cyclacillin) Tablets/ Suspension



Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase prodocers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.*

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY. Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥ 10 mg %, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency

Wyeth Laboratories
Philadelphia, Pa. 19101

The outcome of rehabilitation for patients with COPD is an improved quality of life, with a greater level of activity and a more comfortable existence.

Pulmonary Rehabilitation: Dealing Effectively with Chronic Pulmonary Disease

DONALD F. MAY, R.R.T., and WILLIAM R. KENNY, M.D., *Atlanta**

Introduction

In the past, persons suffering from chronic obstructive pulmonary disease (COPD) have been condemned to a costly and vicious cycle of hospitalization, inactivity at home, decreased quality of life, recurrent infection, and hospitalization. The disabilities brought about by this chain of events have not been dealt with effectively by the medical community. Previous studies and our experience indicate that an aggressive rehabilitation regimen aimed at the lifestyle and symptom complex of the individual with COPD can decrease the effects of the disability and improve the quality of life for this kind of patient.[1, 2]

There are a number of controversial aspects in the rehabilitation of persons with COPD. Among these are the question of long-term cost effectiveness, the value of and potential for physical conditioning, the evidence of objective improvement in pulmonary function, and the possibility of vocational rehabilitation for persons with COPD.[3, 4, 5, 6] More questions remain unanswered, and investigators continue to seek the answers. The value of rehabilitation can be seen in more than mere numbers and graphs. The reduction of symptomatic complaints and the increased physical capability as experienced by the patient also must be considered.

Haas and Cardon[1] found that, "the earlier the rehabilitation treatment is started in the patient with COPD, the greater the cumulative benefit to the patient." A delay in initiating rehabilitation because the patient is not "sick" enough will only make the process longer and more difficult. This article will briefly outline a number of the aspects which need to be implemented in a program of rehabilitation. Each of these aspects is utilized in an individual's program to meet his specific needs. The goals of pulmonary rehabilitation are to facilitate the mastery of certain skills by the individual and to enable him to cope at home and to function more effectively in society.

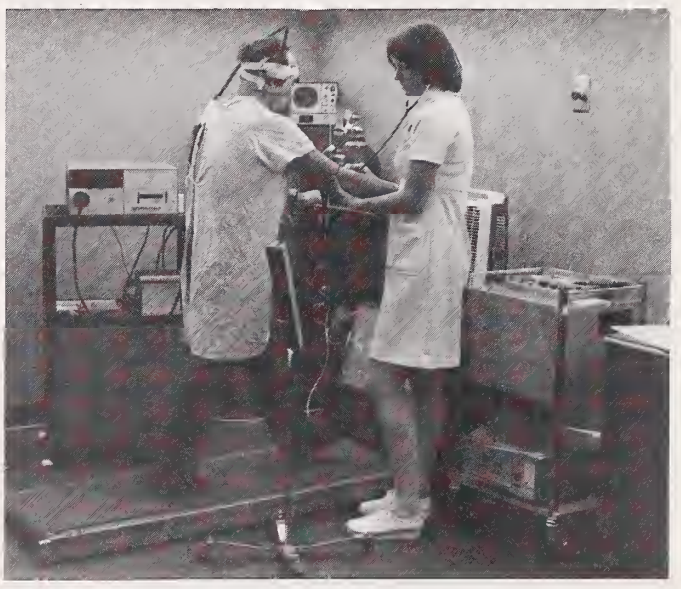


Figure 1 — Nurse monitoring patient during exercise desaturation study with the ear oximeter.

* Mr. May and Dr. Kenny are from the Department of Respiratory Care at Piedmont Hospital. Address reprint requests to Mr. May at the Department of Respiratory Care, Piedmont Hospital, 1968 Peachtree St., NW, Atlanta, GA 30309.



Figure 2 — Patients receive instruction from the nurse and therapist on the anatomy and pathophysiology of COPD.

Physical Reconditioning

The exact mechanisms for improved exercise tolerance after training in persons with COPD are unclear.[3] There are probably many factors in various combinations in each individual case.[7] The beneficial effects of a well-designed exercise program reported by patients cannot be denied and are often both subjective and objective. The fact remains that people do feel better, stronger, and more capable as a result of daily exercise. Lertzman and Cherniack observed that a 2 to 6 week reconditioning program is an effective way of increasing exercise tolerance.[8]

The physical reconditioning aspect of a rehabilitation program is both complex and dynamic. A closely supervised, medically designed exercise program not only allows for safety but also allows for tailoring the exercise and coaching toward specific goals. A study of the metabolites produced at rest and during exercise provides an objective basis for an exercise prescription and evaluation of progress.[5] The standard normals and predicteds for performance do not always apply to the pulmonary patient. The determined ability of these persons can indicate quite different goals and approaches in the rehabilitation regimen.[3, 9, 10]

Supplemental oxygen may sometimes be necessary for the COPD patient during exercise, even though resting blood gases may be adequate.[11] The safest method for determining the precise amount of oxygen needed to maintain adequate saturation is by ear-oximetry with exercise. Once an improvement has been made in exercise tolerance, the reduction or elimination of oxygen with exercise is often possible.[12] With oxygen, levels of exercise not formerly possible can be achieved, thus increasing the amount of physical conditioning in some patients.[3, 9, 11]

Breathing Retraining

Most commonly, breathing retraining is characterized as pursed lip breathing (PLB) and diaphragmatic breathing (DB). These are basic to pulmonary rehabilitation, yet they constitute only part of the whole plan. Coordination and control of breathing are key elements in retraining a person to breathe efficiently. Symptomatic relief and objective improvement in persons using PLB have been reported by a number of investigators.[2, 13, 14] Studies consistently report reductions in respiratory rate and total minute ventilation, and consequential improvement in the ventilatory equivalent.[14] More efficient patterns of breathing have frequently been discovered by the patient on his own, so training can be directed toward coordination and control with exertion. Unless a person masters these techniques and is able to employ them during stress of any origin, the training process is not complete.

During periods of exertion, the COPD patient needs coordination between the activity and ventilation. The objective is to prevent him from holding his breath or increasing his respiratory rate disproportionally to his ability to consume oxygen. A behavior change must take place in the patient. He must learn to perform work on exhalation and maintain an appropriate rate of breathing despite shortness of breath. PLB is a tool to this end.

Learning to control breathing during activities of daily living is not an easy task. Knowledge itself does not change behavior. Consistent encouragement and repetition are needed to enable a COPD patient to use this mode of breathing when he needs it most.

One aspect of breathing retraining frequently ignored is relaxation. Relaxation of both the accessory muscles of breathing and the total body are essential. By reducing the metabolic demands of the body, a more equitable utilization of the available oxygen can be achieved. Some interesting work is now being done in this regard using biofeedback techniques. While relaxation during a period of "air hunger" would seem impossible, most people *can* be trained to relax and control their breathing.[15]

Home Care

It does little long-term good to train a person to breathe and improve his exercise tolerance if his lifestyle is not adjusted appropriately. It is in this area where the individual *must* make certain decisions and commitments. Unless the home care plan is adhered to by the patient, it is difficult to judge its effectiveness. The home routine for self care must be a daily activity. It may be quite involved, or it may only constitute daily exercise and medications. Unless the plan is designed with the patient's personal preferences in mind, it will not work. Because the person with COPD does not always look sick, it is often difficult for family and friends to understand the problems encountered. The family needs to be educated as to what is happening and why, and what can be done about it. Encouragement from family

and friends is essential to help the patient keep up the prescribed activities at home.

Although each home care plan is individualized, the basic components are similar. Each patient needs to attend to the following on a daily basis: exercise, adequate nutrition, adequate fluid intake, medications, bronchial hygiene, and rest. Hobbies and other leisure activities should be encouraged. Television can be a dangerous waste of time for many of these people. The instructional activities that are used to first teach breathing control, etc., need to be reinforced weekly at home. This practice cements these technical skills into the patient's repertoire. It must be stressed that the rehabilitation process is a lifelong process. The patient can never quit and expect to maintain the benefits of his rehabilitation.

The Piedmont Hospital Program

The Piedmont Hospital Pulmonary Rehabilitation Program is designed around an out-patient, day-care concept. The patient must practice at home all the activities he learns in the Program plan. As his ability increases, many of these activities will make up the permanent home care plan. A total of 18 to 20 visits of 3 to 4 hours each are made to the hospital (generally 3 days per week), over a 6 to 8 week period.

There are five general constituents of the program: 1) the initial and follow-up evaluations by a pulmonary physician; 2) breathing retraining; 3) exercise conditioning; 4) education; and 5) therapeutics.

Periodically, counselling sessions are scheduled to discuss goals, progress that has been made, and any problems that might exist. This one-on-one encounter allows the patient to freely express his feelings and helps the staff to effectively tailor the rehabilitation plan. Family involvement is encouraged, and when possible, specific instruction is given to at least one family member.

The individual's motivation is a central issue for all of those involved. Without an appropriate level of motivation, the rehabilitation process is severely hampered. The attitude of the patient toward himself and toward the disease is crucial. The family and friends of the COPD patient can have a tremendous impact on whether or not the patient sees himself as a worthwhile individual. The fear, anxiety, and loss of self esteem experienced by most persons with COPD need to be dealt with in a compassionate and understanding manner.

The following example drawn from our files is not exceptional. It shows what can be done with a proper approach toward rehabilitation in COPD. A 73-year-old man with emphysema was unable to walk one level block. Yardwork and household chores were nearly impossible. His initial maximum oxygen consumption (max. VO_2) was 1.3 liters per minute. After participating in the rehabilitation program, he was walking 1.3 miles before breakfast and often 5 to 8 miles during a day. His post-program max. VO_2 was 1.45 liters per minute — an 11.5% improvement. He was able to do his own yardwork and planted a garden. He was able to play with his grandchildren and felt more secure in all his activities. He now has the skills to cope with his minor breathing problems at home and knowledgeably communicates with his doctor.

Conclusion

The cost effectiveness of rehabilitation for COPD is considerable. Emphysema is second only to heart disease in causing disability and death. Over $750 million is paid annually in Social Security disability benefits to emphysema patients. The average cost of a hospital day is fast approaching $200 per day. A typical patient may require one or more hospital admissions per year of 5 to 10 days. The medical bills for the individual, the insurance carrier, and the government can be staggering.

We have experienced a reduction in hospital days per patient per year as one result of rehabilitation. Petty[2] has reported a 30% reduction in hospital days per patient per year the first year following rehabilitation. The rehabilitation process can be costly initially, yet the savings realized in reduced hospitalization will return the investment many times over in subsequent years.

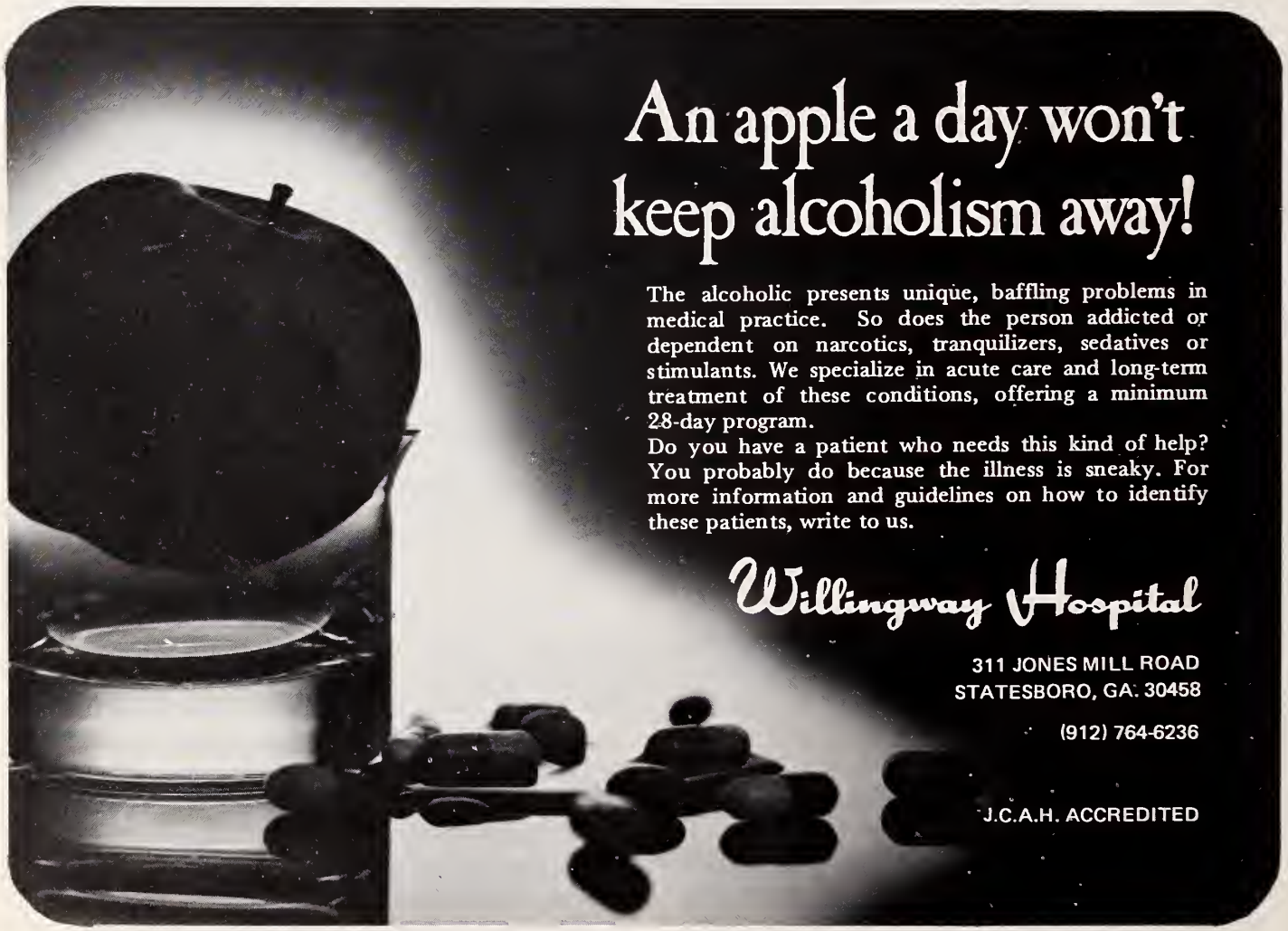
Rehabilitation accompanied by a shift to less physically demanding type of employment would allow many people with COPD to remain gainfully employed or to return to a productive capacity in society.[4] This will not only help the individual's self image, but also reduce the drain on his own and the nation's economic resources. Kass[4] has stated that vocational rehabilitation success or failure is dependant upon psychologic as well as physiologic variables. He has outlined these variables and has given guidelines to follow when assessing potential.

Summary

The rehabilitation of persons with COPD has been shown to be effective in terms of reducing health care costs and reducing the individual's symptom complex.[2, 5, 7, 8] Improved exercise tolerance and oxygen consumption has also been reported.[6, 10, 12] Many questions remain unanswered about COPD and exercise. But a properly designed systematic program of activities does seem to offer the best hope for COPD patients. Inactivity is their own worst enemy. Although it is difficult for them to get about or exercise, it is possible. Something can be done for the COPD patient, and it is important for the patient, his doctor, and the family to know this. Cures and miracles are not the outcome of rehabilitation in COPD, but hard work can yield an improved quality of life and a more comfortable existence.

References

1. Haas A, Cardon H. Rehabilitation in chronic obstructive pulmonary disease. Med Clin N Amer 1969; 53:3.
2. Petty TL. Pulmonary rehabilitation. Basics of RD 1975; 4:1.
3. Degre S. Controversial aspects of physical training in patients with COPD. Pract Cardiol 1979; 5:37-45.
4. Kass I. Correlation of psycho-physiologic variable with vocational rehabilitation outcome in patients with chronic obstructive pulmonary disease. Chest 1975; 64:4.
5. Pierce A. Response to exercise training in patients with emphysema. Arch Int Med 1964; 113:78-87.
6. Shapiro BA. Rehabilitation in chronic obstructive pulmonary disease: a two-year prospective study. Resp Care 1977; 22:10.
7. Petty TL. Does treatment for severe emphysema and chronic bronchitis really help? Chest 1974; 65:2.
8. Lertzman M, Cherniack R. Rehabilitation of patients with chronic obstructive pulmonary disease. Am Rev Resp Dis 1969; 114:1145-1165.
9. Belman M. Exercise physiology and its application in training of patients with COPD. City of Hope Quart 1979; 8:3.
10. Mertens DJ. Long-term exercise therapy for chronic obstructive lung disease. Resp 1978; 35:96-107.
11. Bradley BL. Oxygen-assisted exercise in chronic obstructive lung disease. Am Rev Resp Dis 1978; 188:239-243.
12. Woolf CR. A rehabilitation program for improving exercise tolerance of patients with chronic lung disease. Canad Med Assn J 1972; 106:1289-1292.
13. Motley H. The effects of slow deep breathing on blood gas exchange in emphysema. Am Rev Resp Dis 1963; 88:485-492.
14. Mueller RE. Ventilation and arterial blood gas changes induced by pursed lip breathing. J App Phys 1970; 28:6.
15. Tiep B. Intensive approach toward pulmonary rehabilitation. City of Hope Quart 1979; 8:3.



WE BUILD MEDICAL OFFICES



Architectural

Engineering

Construction

Financing

One Guaranteed Price — No Cost Overuns

We can put together, for you, the Complete Program: DESIGN - DEVELOPMENT - SITE SELECTION - CONSTRUCTION. All work done by professionals under the supervision of State Registered Architects-Engineers and Bonded Contractors all for one guaranteed price. Quality construction, low maintenance and operating costs are built into every building.

For More Information and Preliminary Estimates, Call or Write:

Robert G. Brownlow, President

MEDICAL BUILDINGS AND EQUIPMENT COMPANY, INC.

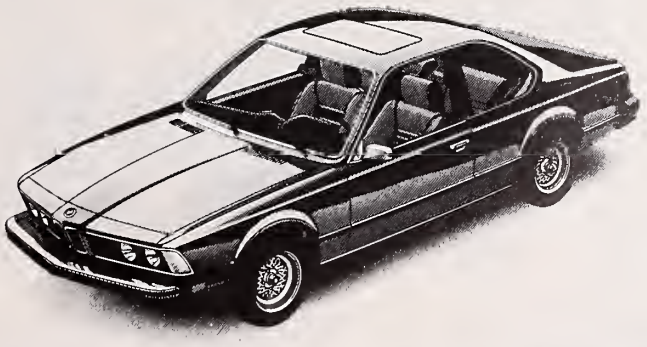
4399 Atlanta Highway • P. O. Box 305 • Loganville, Georgia 30249 • 404/466-2277

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



THE ULTIMATE DRIVING MACHINE.

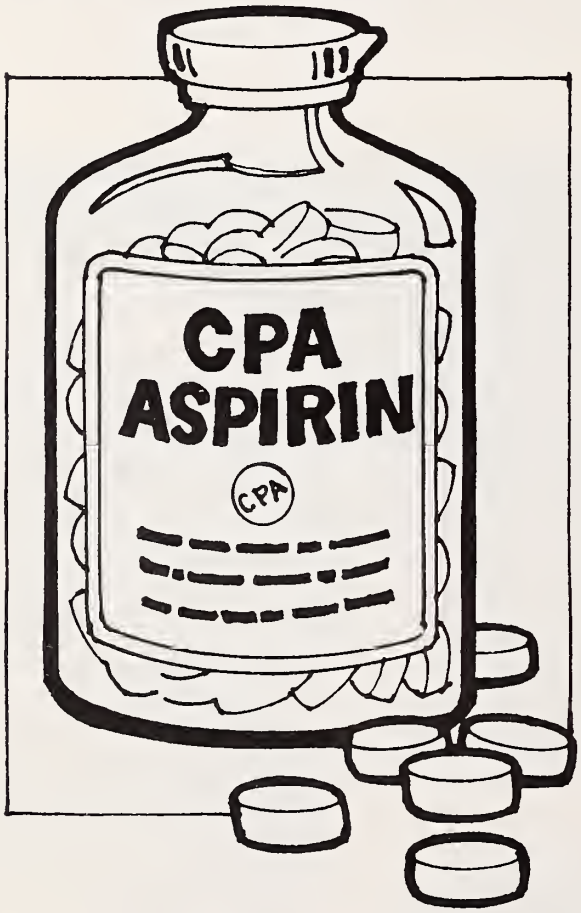
BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730

how do others avoid tax headaches? your CPA knows!



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

Ask a CPA, and be sure

CPA

Georgia Society of Certified Public Accountants

6404

The Complete Communication Company...

OFFICE COMMUNICATIONS INCORPORATED*

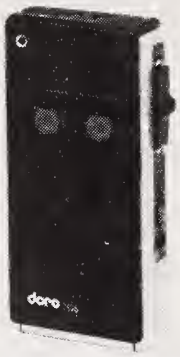
e Portables



NORELCO NT-1



NORELCO 185

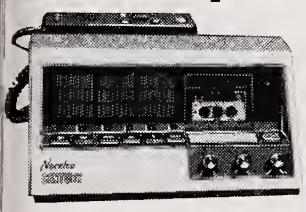


DORO 706



SANYO 1500

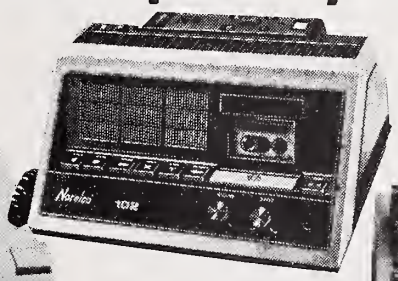
Desk Top Dictation/Transcription Systems



NORELCO CENTURY



DORO 707



DORO 705

NORELCO 102



NORELCO 186

Phone Answering Equipment

SANYO 139



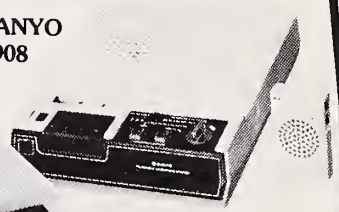
DORO 721



DORO 320



SANYO 9908

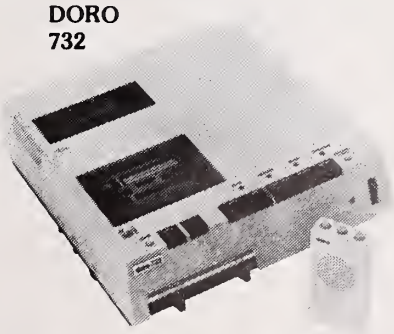


Telephone Dictating

NORELCO 260



DORO 732



*One Stop Communications Sales and Service...

OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry: Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service department throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED

6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.

©WEIGHT WATCHERS INTERNATIONAL, 1977

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Tenuate®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema, *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

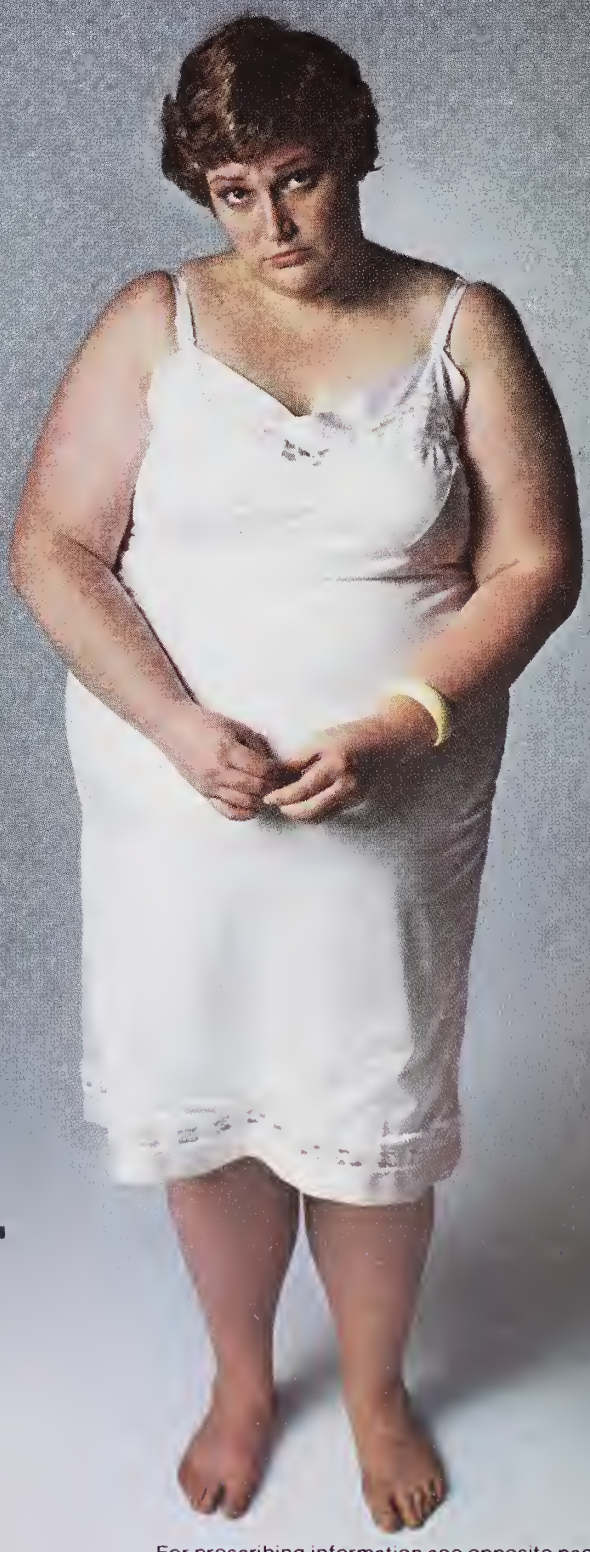
References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

9-4672 (Y957A)

Overweight may not always be simple... complications can develop.*
Complicated or not...

Tenuate® Dospan® ©
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

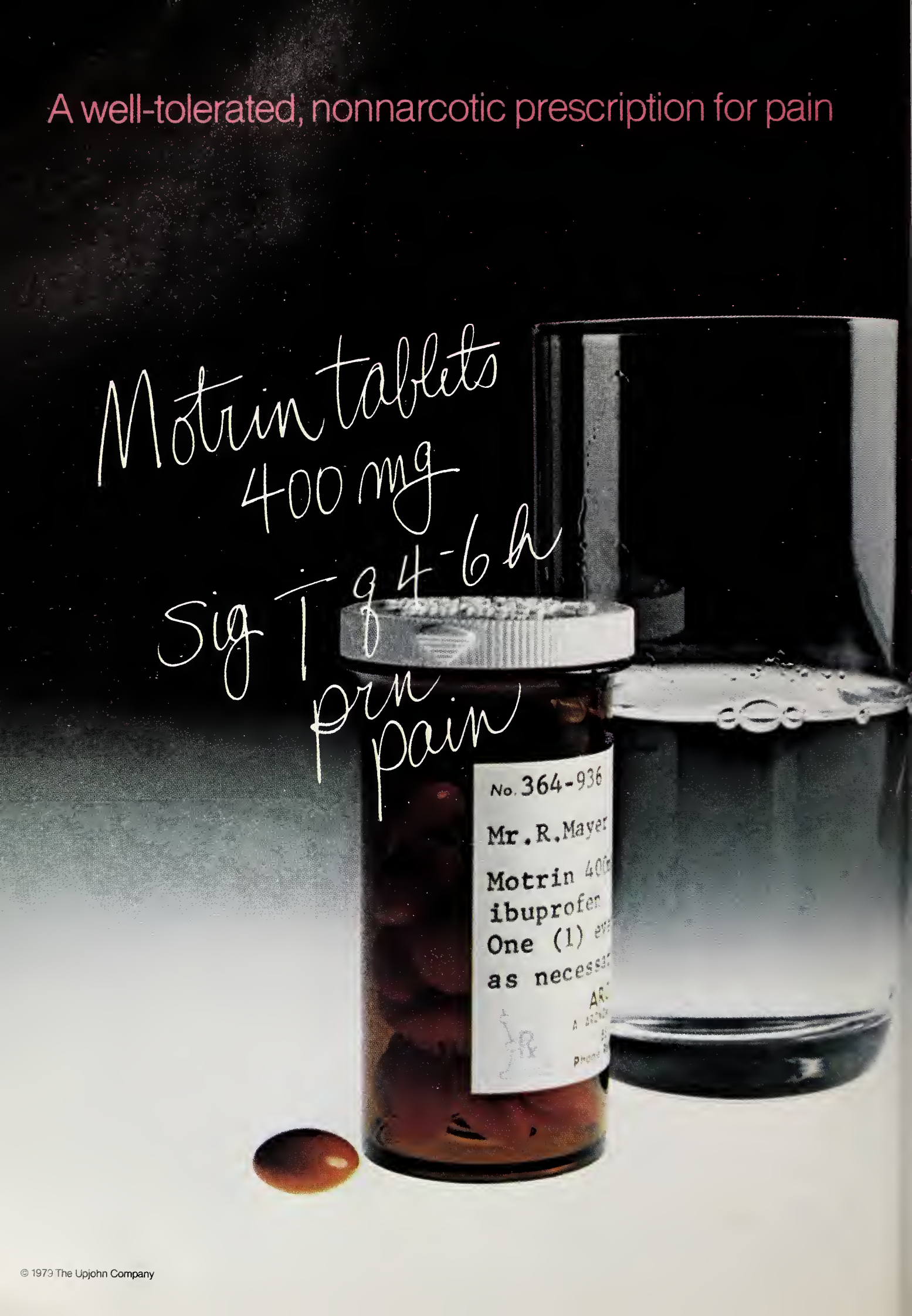
Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

A well-tolerated, nonnarcotic prescription for pain



© 1979 The Upjohn Company

Motrin® now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400 mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

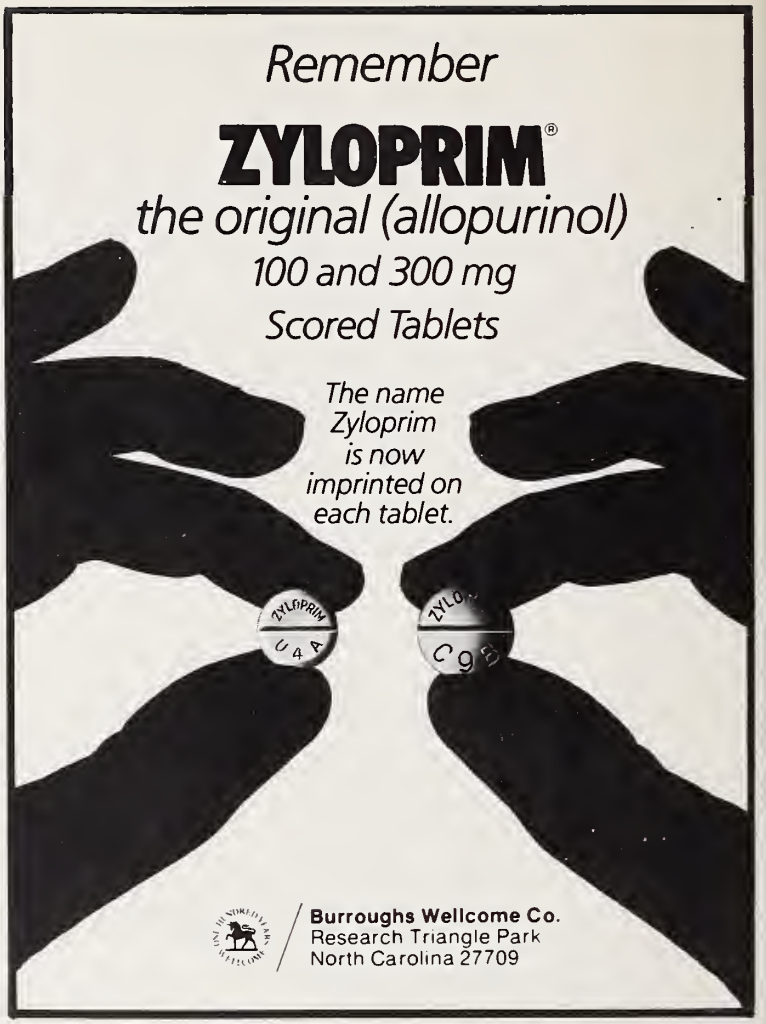
Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

MED B-4-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA





As a result of the changes in the preparticipation physical examinations for junior and high school athletes, the quality of the overall procedure has vastly improved.

Richmond County Sports Medicine Preparticipation Physical Examination Program

ROGER M. SEKLECKI, D.O., MAX D. MILLER, Ed.D., WILLIAM B. STRONG, M.D., and CHARLES W. LINDER, M.D., *Augusta**

Historical Evolution

THREE YEARS AGO, several physicians were approached by the athletic director of the Richmond County Board of Education to help provide physical examinations to a number of the young athletes in some of the schools. The athletic director had noted an obvious discrepancy in the caliber of the physical examinations being given in the county schools, observing that while the athletes of some schools were well attended by the same physician year after year, others were not. Each of the 15 schools developed its own method for making certain that the examinations were performed. The examiner usually was not the same from one season to the next. Therefore, the manner in which the exam was performed varied as well as the level of expertise of the examiner.

During the first year of the program, the exams were performed by the physicians, usually at the schools, using forms that had been used for years. Because of time, space, and resource constraints, little was done to modify or change this process. However, the experience provided an opportunity for assessing the type and quality of examinations that had been given throughout the community in past years.

Many of the physical examinations had been performed in locker rooms, coaches' or nurses' offices, and occasionally in a physician's office. The surroundings were generally noisy, ill-equipped, disorganized, and frequently smelled bad. Except for obvious deformities and pathological conditions, there was an absence of standard disqualifying criteria used by the physicians to determine whether an athlete should be allowed to play or whether any restrictions should be imposed.

Shortly after the initial meeting between the athletic director and the interested physicians, and following completion of the first round of examination, the Richmond County Medical Society developed a Sports Medicine subcommittee which started to enlist other physicians from the Medical College of Georgia faculty and private physicians from the local community. One of the first objectives was to restructure and develop a meaningful and well-designed preparticipation physical examination for the majority of the county's athletes.

One of the first subjects to come to the attention of the committee was the frequency of the examination. During the first year, well over 1,000 physical examinations were done, which meant that a significant amount of time was being directed to a generally very healthy population and that a number of these students would either drop out of the sports program voluntarily or be "cut." Hence, the question arose, "is it absolutely necessary to perform a complete physical examination on every student every year?" Based on the previously indicated observations the committee did not see the need; therefore, a proposal was put before the State's High School Athletic Association to modify the regulation[1] on a trial basis in the Augusta area. The proposal stated, "that a complete physical examination be given to the following students: 1) all eighth grade students or those

* Drs. Seklecki and Miller are with the Department of Family Practice at the Medical College of Georgia, Augusta, GA 30912. Drs. Strong and Linder are with the Department of Pediatrics at MCG.

TABLE 1
DISQUALIFYING CONDITIONS FOR SPORTS PARTICIPATION

Conditions	Contact[1]	Noncontact Endurance[2]	Other[3]
GENERAL			
Acute infections: Respiratory, genitourinary, infectious mononucleosis, hepatitis, active rheumatic fever, active tuberculosis	x	x	x
Obvious physical immaturity in comparsion with other competitors	x	x	
Obvious growth retardation	x		
Hemorrhagic disease: Hemophilia, purpura, and other bleeding tendencies	x		
Diabetes, inadequately controlled	x	x	x
Jaundice, whatever cause	x	x	x
EYES			
Absence or loss of function of one eye	x		
Severe myopia	x		
EARS			
Significant impairment	x		
RESPIRATORY			
Tuberculosis (active or under treatment)	x	x	x
Severe pulmonary insufficiency	x	x	x
CARDIOVASCULAR			
Mitral stenosis, aortic stenosis, aortic insufficiency, coarctation of aorta, cyanotic heart disease, recent carditis of any etiology	x	x	x
Hypertension on organic basis	x	x	x
Previous heart surgery for congenital or acquired heart disease	x	x	
LIVER			
Enlarged liver	x		
SKIN			
Boils, impetigo, and herpes simplex gladiatorum	x		
SPLEEN			
Enlarged spleen	x		
HERNIA			
Inguinal or femoral hernia	x	x	

[1] Lacrosse, baseball, soccer, basketball, football, wrestling, hockey, rugby, etc.
[2] Cross country, track, tennis, crew, swimming, etc.
[3] Bowling, golf, archery, field events, etc.

Conditions	Contact[1]	Noncontact Endurance[2]	Other[3]
MUSCULOSKELETAL			
Symptomatic abnormalities or inflammations	x	x	x
Functional inadequacy of the musculoskeletal system, congenital or acquired, incompatible with the contact or skill demands of the sport	x	x	
NEUROLOGICAL			
History or symptoms of previous serious head trauma, or repeated concussions, Controlled convulsive disorder*	x		
Convulsive disorder not completely controlled by medication	x	x	
Previous surgery on head or spine	x	x	
RENAL			
Absence of one kidney	x		
Renal disease	x	x	x
GENITALIA **			
Absence of one testicle			
Undescended testicle			

*Each patient should be judged on an individual basis. All things being equal, it is probably better to encourage a young boy or girl to participate in a non-contact sport rather than a contact sport. However, if a particular patient has a great desire to play a contact sport, and this is deemed a major ameliorating factor in his/her adjustment to school, associates and the seizure disorder, serious consideration should be given to letting him/her participate if the seizures are controlled.

**The Committee approves the concept of contact sports participation for youths with only one testicle or with an undescended testicle(s), except in specific cases such as an inguinal canal undescended testicle(s), following appropriate medical evaluation to rule out unusual injury risk. However, the athlete, parents and school authorities should be fully informed that participation in contact sports for such youths with only one testicle does carry a slight injury risk to the remaining healthy testicle. Following such an injury, fertility may be adversely affected. But the chances of an injury to a descended testicle are rare, and the injury risk can be further substantially minimized with an athletic supporter and protective device.

Reprinted with permission of the American Medical Association.

TABLE 2 — Classification of Sports

Strenuous — contact
- Football
- Ice hockey
- Lacrosse (boys)
- Rugby
- Wrestling

Strenuous — limited contact
- Basketball
- Field hockey
- Lacrosse (girls)
- Soccer
- Volleyball

Strenuous — noncontact
- Crew
- Cross-country
- Fencing
- Gymnastics
- Skiing
- Swimming
- Tennis
- Track and field
- Water polo

Moderately strenuous
- Badminton
- Baseball (limited contact)
- Curling
- Golf
- Table tennis

Nonstrenuous
- Archery
- Bowling
- Riflery

Figure 1

ATHLETIC HEALTH EXAMINATION RECORD

(1-4) ☐☐☐☐ (Office use only)

School _____ ☐☐ (5-6)

Last Name First Name Middle Initial

Grade _____ ☐☐ (7-8)

Age (9-10) ☐☐ _____ Date of Birth

Race: (11) ☐ 1 Black ☐ 2 White ☐ 3 Other

Sex: (12) ☐ 1 Male ☐ 2 Female

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the State Association.

_____ Date

_____ Signature of Student

Parent's or Guardian's Permission & Release

"I hereby give my consent for the above named student to represent his or her school in the athletic activities except those indicated on this form by the examining physician provided that such athletic activities are approved by the State Association. I also give my consent for the student to accompany the school team on any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above named student in the course of such athletic activities or such travel."

_____ Typed or Printed Name of Parent or Guardian

_____ Signature of Parent or Guardian

_____ Address

_____ Phone

_____ Date

HEALTH HISTORY

(To be completed by student and/or parents)

(13-33)

	1 Yes	2 No	If yes, use the space below to explain:
1.	☐	☐	Any chronic or recurrent illnesses? _____
2.	☐	☐	Any illness lasting more than a week? _____
3.	☐	☐	Any hospitalizations? _____
4	☐	☐	Any surgery other than tonsillectomy? _____
5.	☐	☐	Any injuries requiring treatment by a physician? _____
6.	☐	☐	Presently taking any medications? _____
7.	☐	☐	Any problem with blood pressure or heart? _____
8.	☐	☐	Any dizziness, fainting, convulsions or frequent headaches? _____
9.	☐	☐	Ever been knocked out or had a concussion? _____
10.	☐	☐	Wear eyeglasses or contact lenses? _____
11.	☐	☐	Wear any dental appliance such as braces, bridge or plates? _____
12.	☐	☐	Allergic to ANY medications (aspirin, penicillin, etc.)? _____
13.	☐	☐	Any knee injury? _____
14.	☐	☐	Any knee surgery? _____
15.	☐	☐	Any ankle injury? _____
16.	☐	☐	Any history of neck injury? _____
17.	☐	☐	Any other joint sprains or dislocations (shoulder, wrist, finger, etc.)? _____
18.	☐	☐	Any broken bones (fractures)? _____
19.	☐	☐	Any organ missing other than tonsils (appendix, eye, kidney, testicle)? _____
20.	☐	☐	Any heat exhaustion or heat stroke? _____
21.	☐	☐	Any reasons why this applicant should not participate in sports? _____
			Date of last known tetanus (lockjaw) shot _____

Please use this space if needed to further explain any of the above answers or to provide any additional information: _____

Richmond County Medical Society - 1980

participating in junior high school athletics for the first time; 2) all tenth grade students or those participating in senior high school athletics for the first time; 3) any student who had been injured during the prior year and was under the care of a physician for this injury; and 4) that a modified examination consisting of obtaining the student's height, weight, pulse, and blood pressure be done on all of the other students." This proposal was accepted and is currently being used in the Richmond County Program.

This philosophy is also shared by a number of other physicians who have had similiar experiences. Dr. Thomas Shaffer writes: "Once a baseline of past and present health status has been determined by an examination at the time of initial entry to the sports program, the medical needs of young athletes are more completely served by continuing medical care than by routine physical examinations."[2]

Another major concern of the committee was where the examination should be performed. It was decided to find a central facility where all of the students could be brought and where the examination could be performed with maximum thoroughness and ease. Permission was obtained to use the local county hospital's outpatient clinic facility. The facility is scheduled three times a year for the junior and senior high school students participating in football and basketball.

Since this was a rather large community endeavor, additional medical office assistants, nurses, physical therapists, and residents from the Medical College were asked to participate. This multi-disciplinary examination effort provided sufficient time for review of the medical history, a comprehensive physical examination, discussion, and recommendations.

Preparticipation History

Figure 1 shows the current health history and permission form that is to be filled out by student and/or parents. The coaches are instructed to review each question and explain any word or phrase that may need clarification before the student takes the form home. Those involved in sports medicine should be aware of the causes of sudden, non-trauma-related deaths in young athletes.[3] Any suggestion or historical notation of symptoms such as syncope, heat exhaustion, dizziness, sudden tiredness, or heart-related findings should be brought to the attention of the examining physician.

The history can also help in directing the physical examination toward specific areas and provide additional information to determine whether an athlete should be disqualified altogether from athletics or restricted to particular sports. Special emphasis needs to be placed on those areas already delineated by the AMA and other investigators (Table 1).[4]

Because of the already well documented prevalence of musculoskeletal problems observed in football and basketball, greater emphasis is put into reviewing positive replies in these areas, especially while this aspect of the examination is being done.

Preparticipation Physical Examination

The objectives of the examination are to evaluate the general physical status of the student, screen for and treat any remedial health problems, determine the physiological maturity of the student, make recommendations to the athlete and coach regarding training, rehabilitation, and prevention of future injuries, make appropriate referrals for specific medical problems as needed, impose limitations as needed, and suggest sports that could be safely enjoyed (Table 2).[2]

Over the past 3 years only a few students have been prohibited from any type of athletic competition. A larger percentage were referred to their family physician or specialist for either follow-up work or consultation.

Conclusion

As a result of the above changes in the preparticipation physical examination, the quality of the overall procedure has vastly improved. These efforts have also pin-pointed at least three possible areas of concern: 1) those which require additional consideration, such as the national trend to evaluate physiological maturity of the participants; 2) those that need further refinement, such as improving the degree of standardization of the examination process and its analysis; and 3) those areas which may need to be added to the preparticipation physical procedure, such as a mechanism to follow-up those students with either disqualifying or restrictive conditions. Ultimately, it is the hope of those involved — physicians, physical therapists, and medical assistants — that every student examined will benefit from the comprehensive history and physical, both in terms of injury prevention and increased involvement of the medical community.

Bibliography

1. Georgia High School Association Constitution and Bylaws 1979; 73 (1).

2. Shaffer TE. The health examination for participation in sports. Ped Annals 1978; 7:(10)666-675.

3. Gunby, P. What causes sudden death in young athletes? JAMA 1979; 241:123-124.

4. American Medical Association. Medical Evaluation of the Athlete . . . A Guide, Revised Edition 1976.

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329
404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

editorials
editorials
editorials

Zip Code 303 Welcomes You to the MAG

ZIP CODE 303 (formerly known as Atlanta) welcomes its country cousins from the other 300 areas to the Medical Association of Georgia's annual meeting.

Despite the bad press recently, 303 is still one of the world's great cities, with excellent hotels, restaurants and all kinds of good and bad entertainment. Things look like they are going to be a little safer since 264-86-9847 (the Mayor) is beginning to realize you can't let criminals, bums, drunks, and sociopaths have a free run of the downtown area and still have a viable city. Thanks to 256-84-2217 (the Governor), we were recently rescued by the state patrol during a bad seige of crime, and now things are looking up.

The property taxes are high, the city services have gone down, the schools leave a lot to be desired, and the weather is miserable (as I write this cheery letter). Maybe some day we'll get another 246-85-4223 (former Mayor William Hartsfield) and 247-52-4432 (former Police Chief Herbert Jenkins) so we can reach our real potential. Remember, this town (303) was burned to the ground once by 000-00-0000 (General William T. Sherman) and rose out of its ashes, so maybe we can start rising again.

Don't forget, we'll have a good meeting, the hotels and restaurants are great. And count on spending lots of money, as the business community needs it in this time of recession. Besides, it's tax deductible!

Sincerely,

258-36-5517
(formerly Frank L. Wilson, M.D.)
President Medical Association of Atlanta

P.S. Since everything is getting computerized and it will only work with numbers, I thought I would get used to the new system.

&#@!&$#@!

Doctor Discusses Disability Dollars

AS I WRITE this, a front page article from *The Wall Street Journal* (Dec. 13, 1979) reads, "Health Benefits Grow as a Major Expense for Employers."

Sickness and injury account for at least a half billion lost days from work in this country on an annual basis. Conservatively, this represents an annual cost to industry of over $21 billion. This staggering expense is passed down to all of us — one way or another.

As physicians, we may not be so acutely aware of the billions of dollars of wages that are spent each year by industry for time away from the job resulting from claimed or actual medical disability. Although most physicians carry disability insurance, I would expect us to have low participation in such payments for medical disability. Imagine what would happen to your practice if you were away 3, 6, or 12 months.

Industry, government, and the private sector have for decades entrusted and depended upon the practicing physician to assign and certify such disability for his or her patient. When appropriately done, it is a reasonable means to prevent personal economic disaster while an individual is recovering from sickness disability or injury. This expense or "insurance" for such disability is paid for by us and all productive citizens in every product or service we buy.

In order to re-emphasize the importance of the practicing physician in this decision-making process, and in the interest of the escalating expenses, the 1979 House of Delegates of the American Medical Association adopted the following resolution regarding the physician's role in returning patients to work after they recover from illness or injury.

Resolution: 149

As Amended, Adopted and Referred to American Medical Association Board of Trustees by House of Delegates

WHEREAS, Sickness and injury in America account for more than a half-billion days lost from work each year (estimated by Bureau of Labor Statistics), at a cost to the country of over 21 billion dollars (estimated by National Safety Council); and

WHEREAS, It is in the interest of both worker and employer that sickness absence be kept at the lowest level commensurate with satisfactory convalescence and rehabilitation; and

WHEREAS, Economists agree that better productivity per hour will be an essential feature of our nation's effort to return to a stable economy; and

WHEREAS, Less absence from work would contribute importantly to A.M.A.'s Voluntary Effort to control the rising costs of medical care; and

WHEREAS, Physicians and surgeons are the prescribers of the amount of time an employee should remain away from work for the purposes of convalescence and rehabilitation; therefore be it

RESOLVED, That the American Medical Association encourage physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety.

Adopted July, 1979
Introduced by: American Occupational Medical Association
American Academy of Occupational Medicine

Our economy, industry, and the nation ask for our increased awareness of this issue and seek our assistance.

Sincerely,

Kenneth T. Woodsides, M.D., Atlanta
Member of MAG's Occupational Health Committee

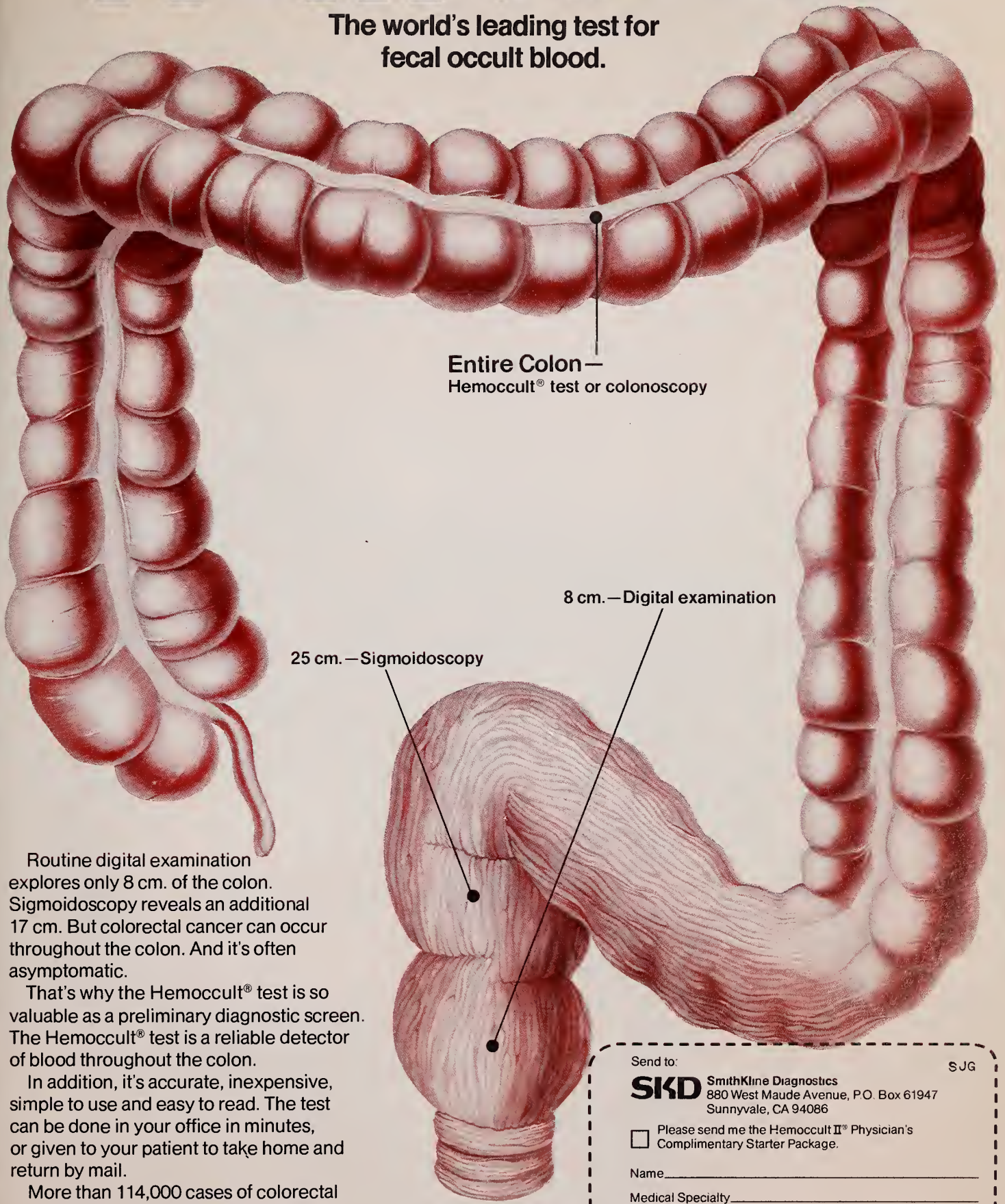


"A man's character is to be judged not by what he knows but by what he loves."

St. Augustine

Hemoccult®

The world's leading test for fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult® test is so valuable as a preliminary diagnostic screen. The Hemoccult® test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 114,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult® starter package, today.

Send to: SJG

SKD SmithKline Diagnostics
880 West Maude Avenue, P.O. Box 61947
Sunnyvale, CA 94086

☐ Please send me the Hemoccult II® Physician's Complimentary Starter Package.

Name_____

Medical Specialty_____

Address_____

City_____ State_____ Zip_____

Phone_____

Hemoccult® is available through local distributors, nationwide.

© SmithKline Diagnostics, 1980

When painful spasm is the presenting symptom . . .



.in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

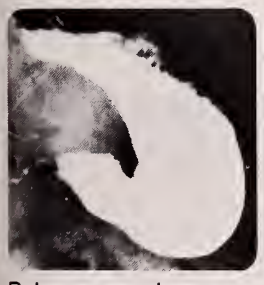
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. AOVERSE REACTIONS. Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

Stanley H. KAPLAN
®EDUCATIONAL CENTER
TEST PREPARATION
SPECIALISTS SINCE 1938

OUR 41st YEAR

Prepare for:

National Medical Boards
VQE•ECFMG•FLEX•TOEFL
Nursing Boards
National Dental Boards

- Stanley H. Kaplan has represented quality test preparation for 40 years. Word-of-mouth recommendations have helped us become the largest test preparation organization in the world with more than 80 centers in the United States and abroad. Our vast resources and experience provide an umbrella of testing know-how that assures you the best preparation possible.
- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.

Flexible Programs and Hours

Please come visit our center

2964 Peachtree Rd., N.W., Suite 654
Atlanta, Georgia 30305
404-262-7582

Centers in major U.S. cities, Puerto Rico, Toronto, Canada, Zurich, Switzerland, and Hawaii

Not-So-Good News for the Good Samaritan

ROBERT N. BERG, *Atlanta**

WE ARE ALL FAMILIAR with the parable of the Good Samaritan who came to the aid of a wounded traveler after the priest and the Levite had come upon him and passed by on the other side.[1] While the Good Samaritan in the parable ultimately received his just reward, the real-life "Good Samaritan" may not be so fortunate. Witness a recent Georgia Court of Appeals case.

Background

At common law, courts refused to recognize a legal duty on the part of a bystander or a passer-by to assist a stranger in distress. Once the bystander came to the aid of another, however, the law placed an affirmative obligation on the bystander to exercise a reasonable degree of care and skill in rendering such aid. This dichotomy between nonfeasance and misfeasance as the basis for determining liability produced some extreme and sometimes shocking decisions. For example, an expert swimmer with a boat and rope at hand who saw another man drowning before his eyes was held to not be liable for sitting on the dock and smoking his cigarette while watching the man drown.[2] Closer to home, the Georgia Court of Appeals held in a 1966 case that the owner of a swimming pool had no duty whatsoever to rescue a child whom he saw drowning in his swimming pool.[3] On the other hand, the physician who rendered medical services to the best of his or her ability in an emergency (as required pursuant to Section 5 of the Principles of Medical Ethics of the American Medical Association) was oftentimes rewarded for his benevolence with a malpractice suit instituted by an ungrateful victim.[4]

In order to avoid this unfair result and to encourage all persons, including physicians, to come to the aid of others, states began in the early 1960s to enact "Good Samaritan" statutes. Among the earliest such statutes was the one enacted in 1962 in Georgia, which provides:

> "Any person, including those licensed to practice medicine and surgery pursuant to the provisions of this Chapter, and including any person licensed to render service ancillary thereto, who in good faith renders emergency care at the scene of an accident or emergency to the victim or victims thereof without making any charge therefor, shall not be liable for any civil damages as a result of any act or omission by such person in rendering the emergency care or as a result of any act or failure to act to provide or arrange for further medical treatment or care for the injured person.[5]

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer, and Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

Thus, the physician who gratuitously and in good faith renders emergency care or treatment to an accident victim may be excused from civil liability in rendering such emergency care or treatment.

From its enactment in 1962 until 1978, no cases were reported regarding the Georgia "Good Samaritan" statute. In addition, when the Georgia Court of Appeals was finally presented with the task of construing the Georgia "Good Samaritan" statute, it did so favorably to the person rendering the emergency aid. Thus, in *Wallace v. Hall,*[6] the Court rejected the plaintiff's argument that the Georgia "Good Samaritan" statute only served to protect *physicians* who gratuitously render professional services in emergency situations from liability for any civil damages, the Court holding that *any person* rendering emergency care at the scene of an accident or emergency is exempt from civil liability as a "Good Samaritan." Similarly, in *Gordon v. Athens Convalescent Center, Inc.,*[7] the Court held that a convalescent center came within the protective ambit of the "Good Samaritan" statute to the same extent as a natural person.

Unlike these cases, however, the most recent construction of the "Good Samaritan" statute by the Georgia Court of Appeals is not so favorable in its construction of the scope of the protections found in the statute.

The Unlucky Good Samaritan

In *Gragg v. Neurological Associates,*[8] a patient experiencing severe headaches, difficulty in walking, and trembling seizures visited his doctor. After examining the patient, the doctor's initial diagnosis was uncertain, and he recommended conducting an angiogram on the patient at an Atlanta hospital.

During the procedure, the doctor inserted the catheter into the patient's femoral artery, and then carefully moved the catheter up through the patient's vascular system to the left carotid artery without any difficulty. After x-rays were taken, however, the doctor encountered difficulty in endeavoring to maneuver the catheter from the left to the right carotid artery. At that time, not wishing to abandon the test or attempt to utilize the riskier alternative method, which is to puncture directly into the artery through the neck, the doctor summoned a second doctor who was present in the hospital but not in the operating room. The second doctor, a specialist in the test, responded to the first doctor's request for aid, and successfully manipulated the catheter into the desired position in about 3 minutes with little difficulty. About 15 minutes after the second doctor departed, the patient suffered a stroke, leaving him with "permanent total paralysis of the left arm and hip and with permanent partial loss of the use of the left arm and hand."

The patient thereafter instituted a suit against both the first and the second doctor. The trial court, solely on the basis of the Georgia "Good Samaritan" statute, granted summary judgment in favor of the second doctor.

On appeal, the Georgia Court of Appeals reversed the trial court, holding as a matter of law that "the hardship encountered during the process of a diagnostic procedure being conducted by an experienced physician did not constitute such an accident or emergency as would invoke the provisions of the Good Samaritan Statute." Crucial to the Court's holding was the fact that the patient was receiving care from a qualified, experienced physician before the second doctor's arrival in surgery; the first doctor had performed the angiogram on 300 occasions prior to the one in question and was aware of the possibility that the difficulty which he in fact encountered could occur.

Moreover, the Court was impressed by the fact that the discontinuance of the angiogram would not itself have placed the patient's health in any immediate danger and that the first doctor was fully capable of proceeding alone in spite of the complication which arose and he would have opted to do so, had the second doctor not been available.

Conclusion

Prior to the adoption of the various state "Good Samaritan" statutes, one of the foremost legal authorities in the area of tort law, in summarizing the distinction which existed between the treatment of the person who failed to come to the aid of a stranger in an emergency and the person who did so, paraphrased the "Good Samaritan" parable as follows: "The result of all this is that the good Samaritan who tries to help may find himself mulcted in damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing."[9] From the *Gragg* decision, holding that not every situation in which a doctor gratuitously treats a patient will be deemed to be an emergency or accident situation so as to enable the treating physician to rely on the protections of the "Good Samaritan" statute, it is apparent that the enactment of the Georgia "Good Samaritan" statute did not in all cases detour the priest and the Levite from passing by on the other side and going on their cheerful way rejoicing.

Notes

1. *Luke,* 10:30-37.
2. *Osterlind v. Hill,* 263 Mass. 73, 160 N.E. 301 (1928).
3. *Handiboe v. McCarthy,* 114 Ga. App. 541, 151 S.E.2d 905 (1966).
4. See cases cited in Annotation, 39 ALR 3d 223 (Supplement).
5. *Ga. Code Ann.* §84-930.
6. 145 Ga. App. 610, 244 S.E.2d 129 (1978).
7. 146 Ga. App. 134, 245 S.E.2d 484 (1978).
8. Case No. 58303, Georgia Court of Appeals (November 28, 1979).
9. Prosser, *Law of Torts* 344 (4th ed.).

TEGA-CODE TABLETS C-111

ANALGESIC - ANTIPYRETIC - SEDATIVE

Each tablet contains:

Acetaminophen	300 mg.
Salicylamide	200 mg.
*Sodium Pentobarbital (derivative of barbituric acid)	10 mg.
*Codeine Phosphate (½gr.)	32.4 mg.

***WARNING: May be habit forming.**

Action: Combination of analgesic and antipyretic with sedative.
Indications: Indicated in cases of severe pains, especially when associated with tension, pains and discomforts of neuralgia, rheumatism and arthritis.
Precaution: Use with caution in persons with known allergies to salicylates and barbiturates and in those with active peptic ulcer.
Warning: Long administration may cause habituation.
Side Effects: Large doses may cause nausea, vomiting, skin rash and sometimes anaphylactic reactions.
Contraindications: Idiosyncrasy to any component.
Supplied: Available in bottles of 100 and 1000.
Dose: Adults, one tablet 3-4 times daily, as directed by a physician.

CAUTION: Federal Law prohibits dispensing without prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

Peachford Hospita
A uniquely positive, comprehens

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge.

Twenty-four hour admittance is offered for all programs.





MEDICAL SERVICE DIRECTORS

BOAZ HARRIS, M.D.
Medical Director

CONWAY HUNTER, JR., M.D.
Director, Addictive Disease Unit

CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

JOHN B. HARDMAN, M.D.
Director, Children's Unit

ogram of recovery...that's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

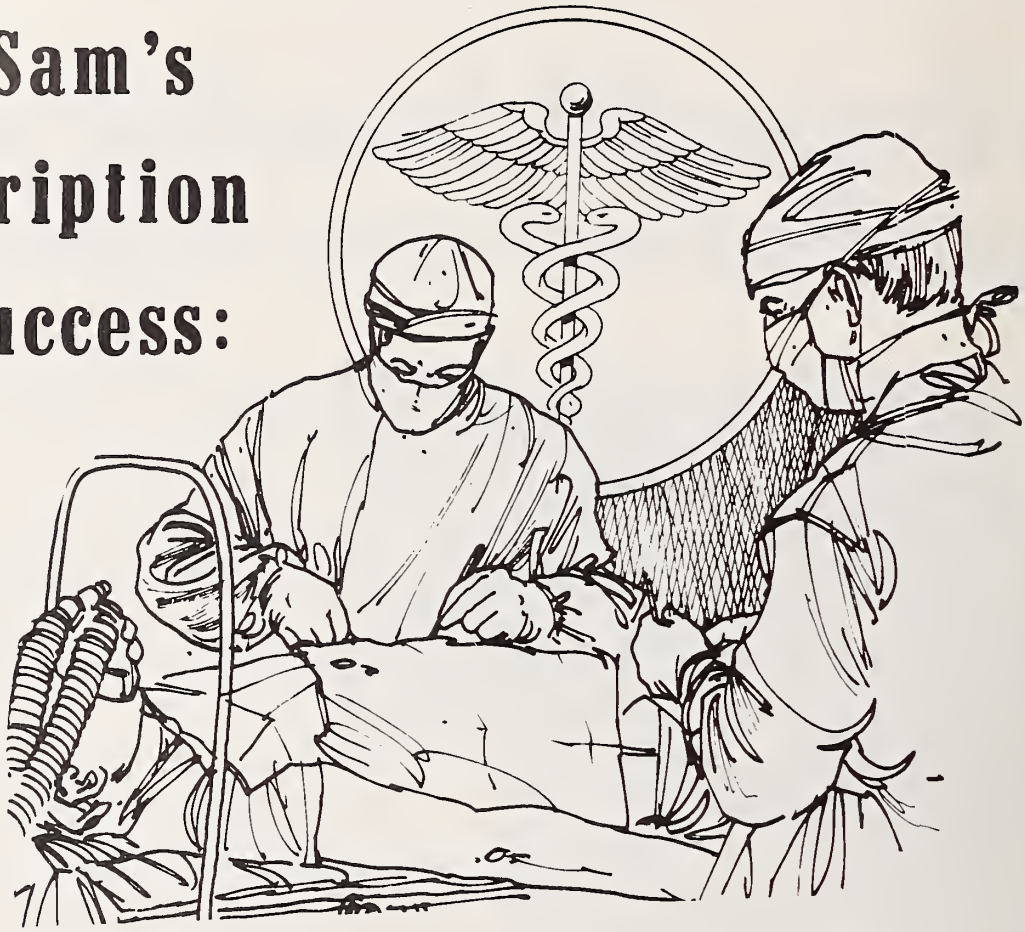
Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

plete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30338
Phone (404) 455-3200



Uncle Sam's Prescription For Success:



Medicine and the Ga. National Guard

As a physician in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found...service to community, state and nation.

In addition, many persons have found that the change of place and change of pace have resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for the Georgia Army National Guard units. Physicians receive monetary support for attending approved CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. **WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS.** If you need that **CHANGE OF PLACE** and **CHANGE OF PACE**, contact:

ARMY NATIONAL GUARD
The Guard belongs.

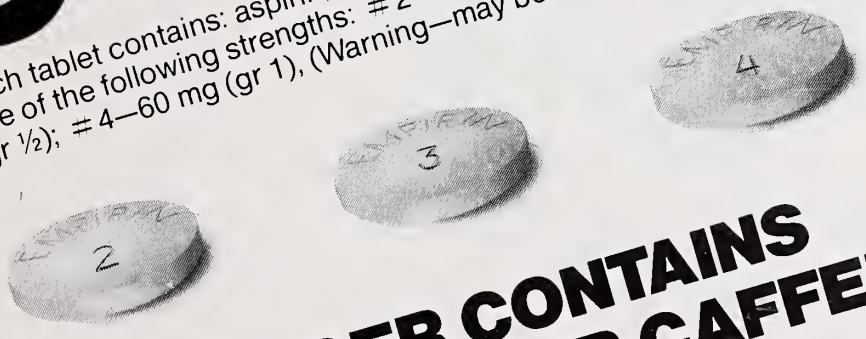
Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662

~~EMPIRIN®~~
~~COMPOUND~~
~~C CODEINE~~
IS NOW

EMPIRIN®
C CODEINE



Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg (gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)



NO LONGER CONTAINS PHENACETIN OR CAFFEINE.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action **Triavil**®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

Copyright © 1980 by Merck & Co., Inc.

by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

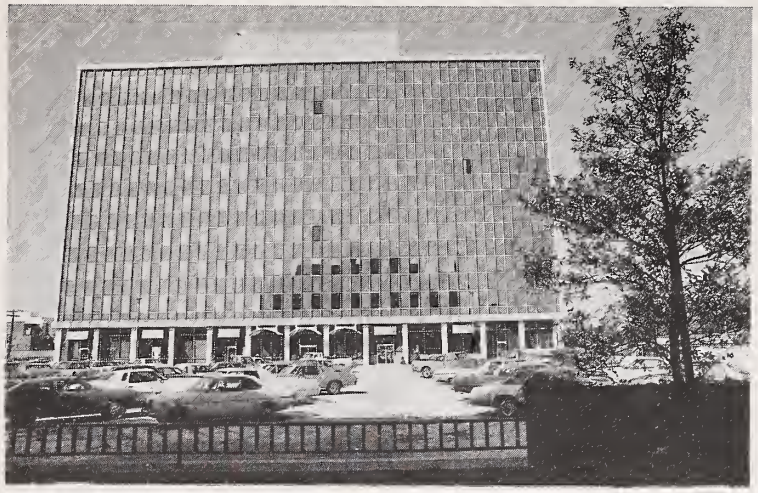
Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered. J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

DECATUR NORTH PROFESSIONAL BUILDING



- ADJACENT TO DECATUR HOSPITAL IN HEART OF DECATUR
- WITHIN TWO MILES OF DeKALB GENERAL VETERANS ADMINISTRATION AND EMORY UNIVERSITY HOSPITALS
- TWO BLOCKS FROM DECATUR MARTA RAPID TRANSIT STATION
- NINE STORIES WITH 87,000 SQUARE FEET
- ON-SITE OWNER MANAGEMENT
- COVERED PARKING FOR TENANTS
- TWO HOURS' FREE PARKING FOR PATIENTS
- ON-PREMISES PHARMACY, RADIOLOGICAL DEPARTMENT, LABORATORY, MEDICAL SUPPLIES, OPTICAL SHOP, BARBER SHOP AND SANDWICH SHOP

The Decatur North Professional Building, specializing in space for professional practices, is located in the Heart of Decatur and close to four major hospitals. Within easy access to bus and rail transportation, Decatur North Professional Building is quickly accessible to Atlanta and other points in metropolitan Atlanta.

EQUITABLE

CALL:
MARTIN D. TAFFEL, PROPERTY MANAGER
Decatur North Professional Building
755 Columbia Drive, Decatur, Georgia 30030
Leasing Information 404/377-9984 or 586-1165

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

president's letter



MAG's Holy Grail

MANY YEARS AGO, a brave and true young knight, Sir Lancelot, yearned to find the Holy Grail, the cup that Jesus had drunk from at His Last Supper. Sir Lancelot wanted this more than anything else in the whole world . . . except perhaps Lady Guinevere.

He was so obsessed with finding this precious cup that he went around the world in search of it. He fought dragons and endured untold hardships, to no avail. After several years, he started for home, empty-handed, tired, and discouraged.

As he approached his castle after the long journey, he saw an aged beggar pick up a tarnished, old cup and get a drink of water out of his (Sir Lancelot's) own moat. His curiosity aroused, Sir Lancelot went over and looked at the cup. On close inspection, he discovered it was actually the coveted Holy Grail. He was stunned! After searching all over the world, he had found this treasure virtually in his own back moat!

So, don't go to Atlanta, Chicago, even Hawaii, or around the world looking for MAG's Holy Grail. Our Holy Grail consists of our ability to give excellent patient care, and we will find this precious treasure in our own offices (moats).

Sincerely,

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

NEW MEMBERS

Abellera, Eudora M., Newton-Rockdale—ACT—IM
1400 Milstead Rd., Ste. C. Conyers 30207

Aupont, Pierre, Clayton-Fayette—ACT—AN
225 Johnson Rd., Apt. 40-F, Forest Park 30050

Beveridge, Wayne, Richmond—ACT—N
Medical College of Georgia, Neurosurgery Dept., Augusta 30912

Bowen, Edward L., Gwinnett-Forsyth—ACT—GP
Box 507, Snellville 30278

Boyle, Lawrence P., Jr., MAA—ACT—GS
105 Collier Rd., NW, Ste. 1020, Atlanta 30309

Brooks, Betty Sue, Richmond—ACT—DR
Medical College of Georgia, Radiology Dept., Augusta 30912

Bussey, John R., MAA—N2—EM
1968 Peachtree Rd., NW, Atlanta 30309

Calhoun, A. Douglas, Dougherty—N2—GS
810-13th Ave., Albany 31701

Cheng, Yueh Ying, Sumter—ACT—PD
317 W. Lamar St., Americus 31709

Cook, Katie E., Richmond—N2—AN
Medical College of Georgia, Anesthesiology Dept., Augusta 30901

Cuttone, James M., MAA—ACT—OPH
705 Juniper St., NE, Atlanta 30308

Dennison, David R. M., MAA—N2—IM
3280 Howell Mill Rd., NW, Ste. 317, Atlanta 30327

Dicks, Robert E., III, Crawford W. Long—N2—NS
1010 Prince Ave., Athens 30606

Elguindi, Ahmed S., Richmond—ACT—PUD
Medical College of Georgia, Augusta 30912

Elsner, Carlene W., Muscogee—N2—OBG
Doctors Bldg., Ste. 110, Columbus 31901

Elsner, William, Muscogee—N2—N
Doctors Bldg., Ste. 110, Columbus 31901

Epple, Walter D., Richmond—ACT—N
3623 J. Dewey Gray Cir., Ste. 310, Augusta 30909

Fatteh, Meboob M., Richmond—N2—PTH
Medical College of Georgia, Pathology Dept., Augusta 30912

Gober, H. Fred, Hall—N2—OBG
1100 Vine St., Gainesville 30501

Goldsmith, Barry J., Richmond—N2—OBG
3623 J. Dewey Gray Cir., Ste. 108, Augusta 30909

Griffin, E. Rawson, III, Muscogee—Service—FP
P. O. Box 350, Ft. Benning 31905

Guzman, Gerardo H., Southeast Georgia—N2—GP
P. O. Box 448, Soperton 30457

Hagler, James R., Sr., Muscogee—N2—GP
P. O. Box 155, Buena Vista 31803

Haile, Kenneth L., Jr., Cobb—N2—TR
Kennestone Hospital, Radiotherapy Dept., 677 Church St., Marietta 30060

Harwell, Derek S., Richmond—ACT—AN
Medical College of Georgia, Anesthesiology Dept., Augusta 30901

Hornback, William L., III, Tift—N2—ORS
1493 Kennedy Rd., Tifton 31794

Keller, John A., Clayton-Fayette—ACT—FP
100 N. Park Dr., Fayetteville 30214

Klein, Steven H., Gwinnett-Forsyth—N2—PD
2354 E. Main St., Snellville 30278

Knowlton, Gregory B., MAA—N1—NEP
5669 Peachtree-Dunwoody Rd., NW, Atlanta 30342

Levy-Eliceiri, Carlos A., Camden-Charlton—ACT—GS
905-A Dilworth St., St. Mary's 31558

Luetkemeyer, John L., Muscogee—Service—IM
5925 Old Dominion Rd., Columbus 31904

Mayer, Barry S., Thomas Area—ACT—DR
P. O. Box 736, Thomasville 31792

Mize, C. Shannon, Gwinnett-Forsyth—N2—FP
P. O. Box 669, Cumming 30130

Moreland, Steven C., MAA—N2—OBG
105 Collier Rd., NW, Ste. 1080, Atlanta 30309

Murphy, Christine H., MAA—N1—R
Emory University Clinic, Radiology Dept., Atlanta 30322

Pierleoni, E. Ernest, Habersham—ACT—IM
P. O. Box 667, Demorest 30535

Pilon, Robert N., Crawford W. Long—ACT—AN
797 Cobb St., Athens 30601

Pirkle, Quentin R., Jr., MAA—ACT—IM
105 Collier Rd., NW, Ste. 2070, Atlanta 30309

Roberts, Michael F., Richmond—N2—PD
1727 Central Ave., Augusta 30904

Rucker, Benjamin L., Richmond—ACT—IM
Talmadge Memorial Hospital, Augusta 30912

Tucker, Thomas S., MAA—ACT—IM
6500 Vernon Woods Dr., NE, Ste. A-2, Atlanta 30328

Ward, William G., MAA—A—GS
Grady Memorial Hospital, Surgery Dept., Atlanta 30303

Wilson, Torrence M., Muscogee—Service—U
Martin Army Hospital, Urology Clinic, Ft. Benning 31905

Wylie, William J., Richmond—A—IM
Medical College of Georgia, Augusta 30902

PERSONALS

First District

The Candler General Hospital in Savannah has elected their new officers for 1980. They are: **John M. Fillingim, M.D.,** chief-of-staff; **Robert A. Wynn, M.D.,** chief-of-staff-elect; **Wesley J. Ball, M.D.,** secretary; **Thomas L. German, M.D.,** treasurer; **Edgar J. Filson, M.D.,** immediate past chief-of-staff; and **Daniel W. Rose, M.D., Dan H. Willoughby, M.D.,** and **Julian K. Quattlebaum Jr., M.D.,** executive committee members-at-large. Department chairmen include **G. Donald Clarke, M.D.,** anesthesiology; **George G. Haberman, M.D.,** emergency; **Fred O. Kessler Jr., M.D.,** family practice; **Thomas M. Stanley, M.D.,** medicine; **David W. Fillingim,** OB-GYN and pediatrics; **Roderick L. Guerry, M.D.,** pathology; **Gordon C. Carson, M.D.,** radiology; and **Thomas R. Freeman, M.D.,** surgery.

Claxton physician **Curtis G. Hames, M.D.,** has donated land for a proposed new county library for Evans County.

Third District

General Surgeon **Larry Brightwell, M.D.,** has recently moved his practice to Columbus after 3½ years in Richland.

Dee B. Russell, M.D., Columbus, has been named a Diplomate of the American Board of Family Practice.

Fourth District

Robert M. Fine, M.D., a Decatur dermatologist, was recently elected to the Board of Directors of the American Academy of Dermatology.

Fifth District

Grune and Stratton has released a new book, *The Aorta,* edited by Joseph Lindsay Jr., M.D., professor of medicine at George Washington University, and **J. Willis Hurst, M.D.,** professor and chairman of Emory's Department of Medicine, Atlanta. Several MAG members are among the 20 contributors. They are **Dorothy E. Brinsfield, M.D., Garland D. Perdue, M.D., William H. Plauth Jr., M.D., Robert B. Smith III, M.D.,** and **Panagiotis N. Symbas, M.D.,** all of Atlanta.

William A. Mason, M.D., Atlanta, retired from his position as Planned Parenthood's Medical Director effective Nov. 30, 1979. He had served in that capacity since May 1974.

Alan Lane Plummer, M.D., associate professor of medicine at Emory School of Medicine in Atlanta, has been elected to a 2-year term as president of the Georgia Thoracic Society. **Joseph I. Miller, M.D.,** assistant professor of thoracic and cardiovascular surgery at Emory University Clinic, Atlanta, was chosen president-elect.

W. Kevin Thomas, M.D., of Doraville, was recently elected as a trustee of the Medical Association of Atlanta.

Charles L. Whisnant, M.D., Director of the Alcohol and Drug Unit, Peachtree and Parkwood Mental Health Center and Hospitals, and **Dave M. Davis, M.D.,** Director of Psychiatric Services, recently completed a series of programs for representatives of the Atlanta business community. Dr. Whisnant spoke on alcoholism, and Dr. Davis presented an overview of mental health problems.

Seventh District

Rome physician, **Hamilton Dixon, M.D.,** spoke to the Baptist Brotherhood on Jan. 14. His topic was Operation Touch, an annual medical missionary endeavor.

General surgeon **Jack Gent, M.D.,** has established an office in Calhoun.

Eighth District

Russell Acree, M.D., has recently moved his practice to Adel.

Richard L. Benson, M.D., chief of radiology at the Coffee General Hospital in Douglas, recently completed a 2-week course in arteriography at Charity Hospital, New Orleans, LA.

J. Ted Holloway, M.D., director for the Southeast Health District, was recently selected to participate in the 1980 Leadership Georgia Program. Leadership Georgia is a group of 60 representatives from business, industry, and the professions whose purpose is to work together towards solving problems that face Georgians.

Ninth District

C. Neil Kelley, M.D., a pulmonary disease specialist from Gainesville, was recently elected secretary-treasurer of the Georgia Thoracic Society.

SOCIETIES

At their December meeting, the members of the **DeKalb Medical Society** heard Fourth District Congressman Elliott Levitas. He reported on current events and health related issues now pending before the United States Congress.

At its December meeting, the **Medical Association of Atlanta** honored six Atlanta physicians who have practiced medicine for 50 years. Those who received certificates were Herbert S. Alden, M.D., Mason I. Lowance, M.D., Carter Smith Sr., M.D., E. Van Buren, M.D., J. Harry Rogers, M.D., and W. Mercer Moncrief Jr., M.D. At the same time, eight other members were designated life members. They were C. Steadman Glisson Jr.,

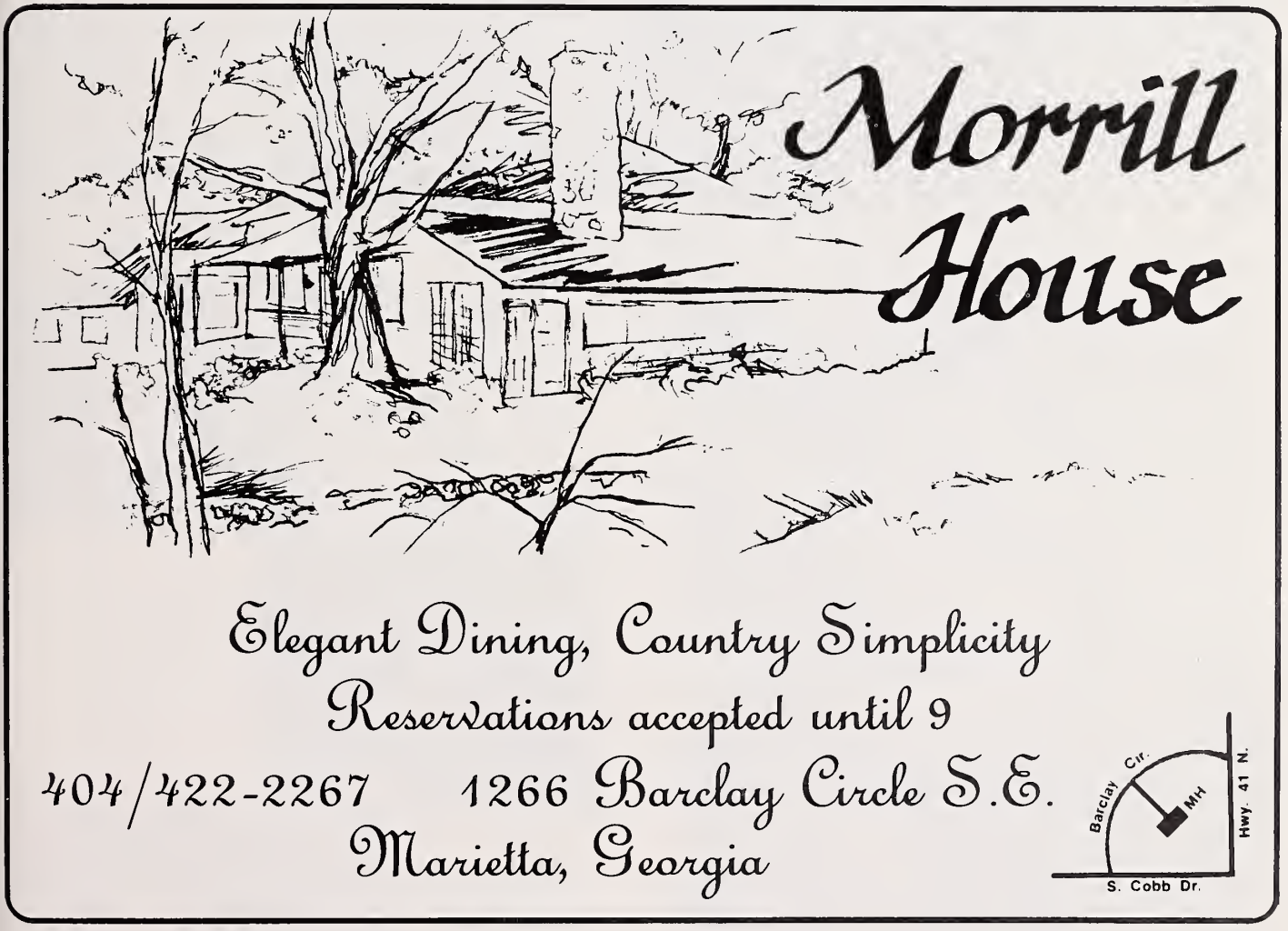
M.D., Allen G. Hauck, M.D., Marvin A. Mitchell, M.D., Arthur M. Pruce, M.D., William N. Harper, M.D., Cyrus W. Strickler Jr., M.D., Bernard P. Wolf, M.D., and Edna S. Porth, M.D.

At its January meeting, the **Muscogee County Medical Society** presented awards to the winners of the Physicians Beeper Tennis Tournament. Marvyn Cohen, M.D., Columbus, and Bobby Flowers, M.D., Columbus, received first place awards. Walker Harris, M.D., Columbus, and Sandra McCann, M.D., Columbus, were runners-up. The Society also held a dinner honoring Muscogee County legislators. Harrison L. Rogers, M.D., of Atlanta, spoke to the group. Special guests included James Kaufman, M.D., chairman of the MAG Committee on Legislation, and Rusty Kidd, Director of Legislative Activities for MAG.

U.S. Mortality Rates, Con't from p. 188

catarrhal affections is reported under that head. The annual rates of pneumonia for the three regions were as follows: on the Atlantic coast, 25.7 cases per thousand of mean strength, the deaths being 131.1 per thousand cases, or one death to every 7.6 cases; in the Central region the cases were 64.2 per thousand of mean strength, the deaths 239.2 per thousand, or one to every 4.1; on the Pacific slope the cases were 20.9 per thousand of mean strength, the deaths 13.1 per thousand cases, or one to 76.

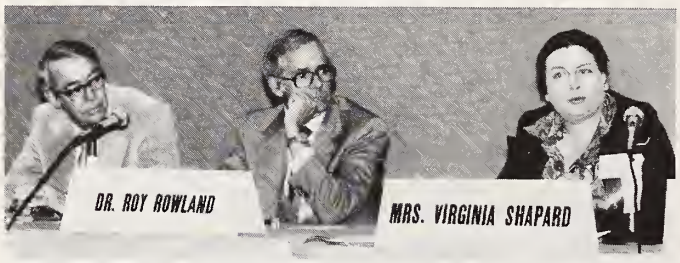
This makes the percentage for the year 456.47 on the Atlantic border; 427.20 in the Central region; and 407.61 on the Pacific coast.



Highlights of MAG's recent PR workshop are presented, along with an assessment of the current state of the PR art.

The Ball is in *Your* Court

CHARLES W. McDOWELL JR., M.D., *Decatur,* and KENNETH M. WILLIAMS, *Atlanta**



Panelists Hal Suit, J. Roy Rowland, M.D., and Virginia Shappard commenting on, "What the Public Thinks of Medicine."

On Jan. 19, 1980, the Medical Association of Georgia's (MAG) Public Relations (PR) Committee sponsored a PR Workshop in Atlanta. Each county society president, president-elect, secretary, and staff was invited. So were all the specialty society presidents, the MAG committee chairmen, the Board of Directors, and the Executive Committee. The purpose of our meeting was to inform physician leaders as to the meaning and importance of good PR. We learned what the public thinks of medicine from those inside and outside of medicine.

The panelists included commentator Hal Suit, WXIA-TV, Atlanta; Mrs. Virginia Shappard, a member and former chairperson of the North Central Georgia Health Systems Agency (HSA); Dr. J. Roy Rowland, a state representative from Dublin; Dr. Tim Ryles, Administrator of the Department of Consumer Affairs for Georgia; Mr. Lou Davis, a commentator with WSB-TV, Atlanta; and Mr. Roger Witherspoon, Health & Science Editor of *The Atlanta Constitution*.

We asked each panelist and speaker to be candid, to tell us not what we *wanted* to hear but what we *needed* to hear. We were impressed with the sincerity of the panelists in discussing not necessarily their own views of medicine but what they had gleaned about the public's views from their professional vantage points. Here is a sampling of some of their comments:

"Doctors earn too much money."

"Who can afford to be sick anymore?"

"You must start policing yourselves — get rid of your bad apples."

"The public thinks less of you now than it did only five or ten years ago."

"It is time that you realize you must concern yourselves with your image."

Probably none of these comments surprised us, but we should still be concerned. Do they accurately reflect what the public thinks? If so, we have a problem.

Assuming that even half of these comments reflect growing public concerns of medicine, what can we do? We may want to bask in the fact that the latest polls indicate that almost 90% of the public was satisfied *overall* with their latest visit to a doctor. Yet, more correctly, we should be concerned that less than half were satisfied with the explanation made by their doctor, that only 61% were satisfied with the treatment by the doctor's staff, and that only 52% were satisfied with the length of office waiting time. Can we be satisfied with the latest polls indicating that 75% of the public rates medical doctors as "excellent or pretty good"? Or should we ask, what about the 25% who rate us less? We should be concerned with these different perspectives.

How do your patients feel about you? What about their complaints — do they have any? If so, can they confide in you? Is the waiting time in your office kept to a minimum? Are your patients comfortable with the length of time it takes to get an appointment? Do your patients understand the charges for the services you give or order? Do you encourage them to discuss their concerns? Are your patients pleased with how your office staff treats them?

* Dr. McDowell practices ophthalmology and is Chairman of MAG's Public Relations Committee. His address is 500 Irvin Court, Ste. C-120, Decatur, GA 30031. Mr. Williams is MAG's Director of Professional and Public Relations. His address is 938 Peachtree St., NE, Atlanta, GA 30309.



The Tower Place Hotel hosted MAG's PR Workshop. The nearby towering office complex remains one of the most unusual and beautiful of its kind in Atlanta.



Charles W. McDowell Jr., M.D. (L), Chairman of MAG's Public Relations Committee, encourages county societies to step up their PR efforts.



Ken Williams (R), MAG's Director of Public and Professional Relations, reports on the Association's PR activities.



Dr. Tim Ryles (L), Administrator of the Georgia Department of Consumer Affairs, says physicians must maintain the quality of medical care despite attempts at cutting costs.



From our workshop and the literature, we have learned that public relations is analagous to medicine. Just as medicine is the art and science of healing, PR is the art and science of developing reciprocal understanding between us as physicians and our patients — the public. What kind of a PR person are you? If you have read this far, the answer is that you are probably pretty good. But what about those that never concern themselves with "image" or the polls? What about these "sinners"?

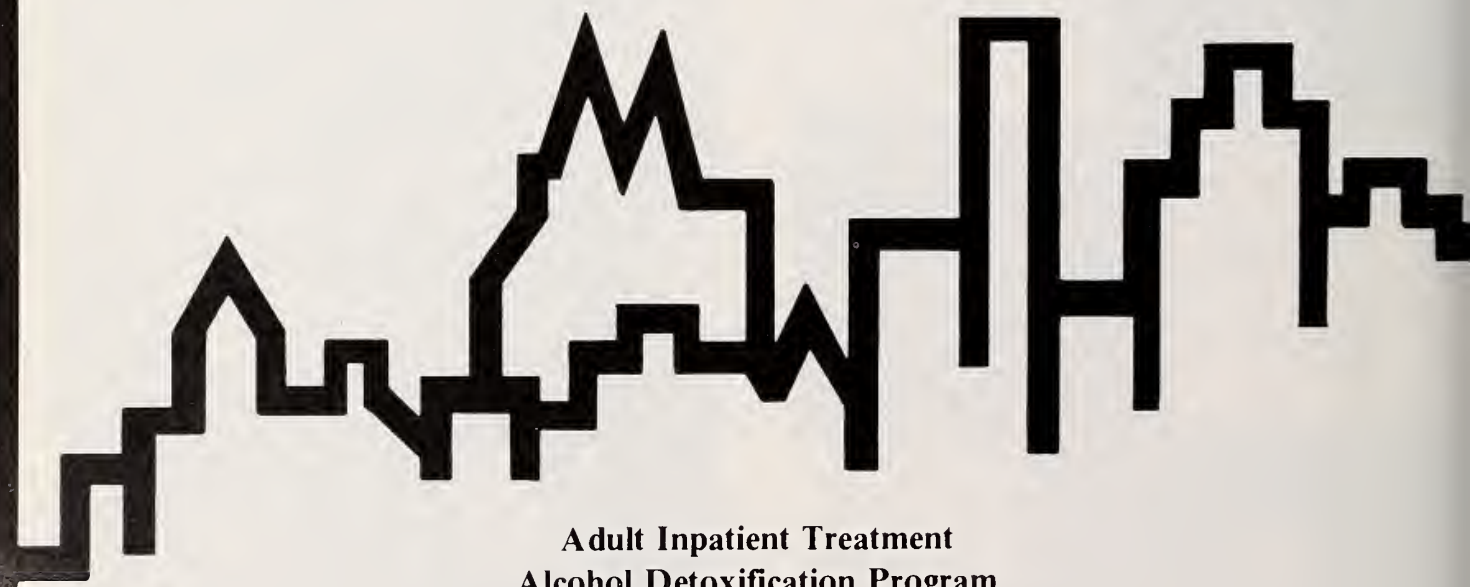
We encourage you to discuss with your county society president the need for scheduling PR as a topic for one of your upcoming meetings. If he is agreeable, call the MAG and ask for help in putting together such a program. We think the recent PR Workshop was only a first step in a long process of improving our PR. Talk to someone who did attend, and ask him what he learned.

The response to date from those with us on January 19 was, right on! We have learned what we need to know to begin to tackle the tasks ahead. What we also learned was that it will be up to each of us to establish in the public's mind their image of medical practitioners — of medicine. If we truly want the public to have "understanding for and goodwill toward" medicine, then that greater understanding between physicians and the public must begin with us — at the local level.

So, the next time you get concerned about how the public feels about medicine in general, about "our" public relations efforts, ask yourself, "How do my patients feel about me?" They probably feel much the same about doctors and medicine as they feel about the caliber of care you offer them and the interest you show in them in the solving of their problems.

The ball is in *your* court.

Specialized Health Care in the Heart of Atlanta



Adult Inpatient Treatment
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

Psychiatric Institute of Atlanta • 811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

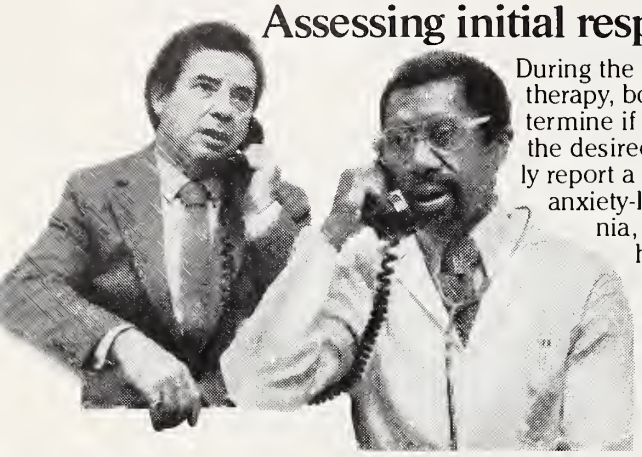
JOURNAL
of the medical association of
georgia
ISSN·0025·7028 APRIL / 1980



HOSPICE care for the terminally ill

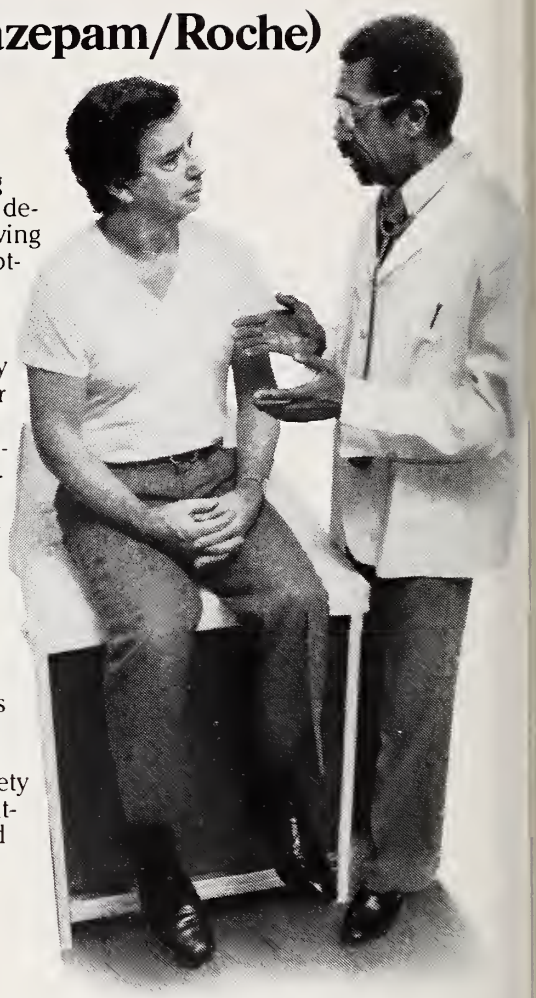
LIBRARY
U.C. SAN FRANCISCO
APR 24 1980

Monitoring patient response to Valium® (diazepam/Roche)

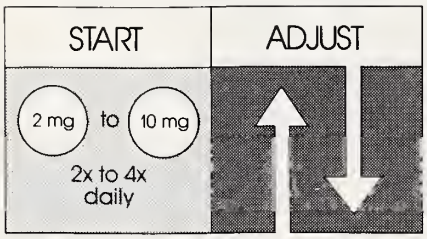


Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments



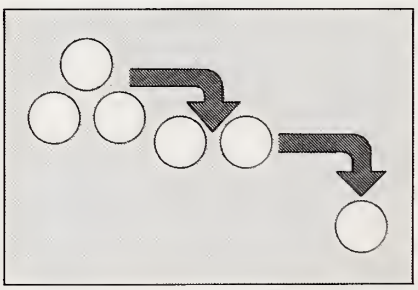
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

2-mg, 5-mg, 10-mg scored tablets

Valium® (IV)
diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

ROCHE®

See the following page for a summary of product information.

Valium® (diazepam/Roche) Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

ROCHE®
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

SAILING YACHTS
BROKERAGE & SALES

SAILING SCHOOL
(COASTAL GEORGIA)

CHARTERS

BLACKBEARD YACHTS LTD.
3483 PEACHTREE ROAD N.E. ATLANTA, GEORGIA 30326

J. S. JURSKIS
PRESIDENT
404-233-9463

Ballard's

DISPENSING OPTICIANS

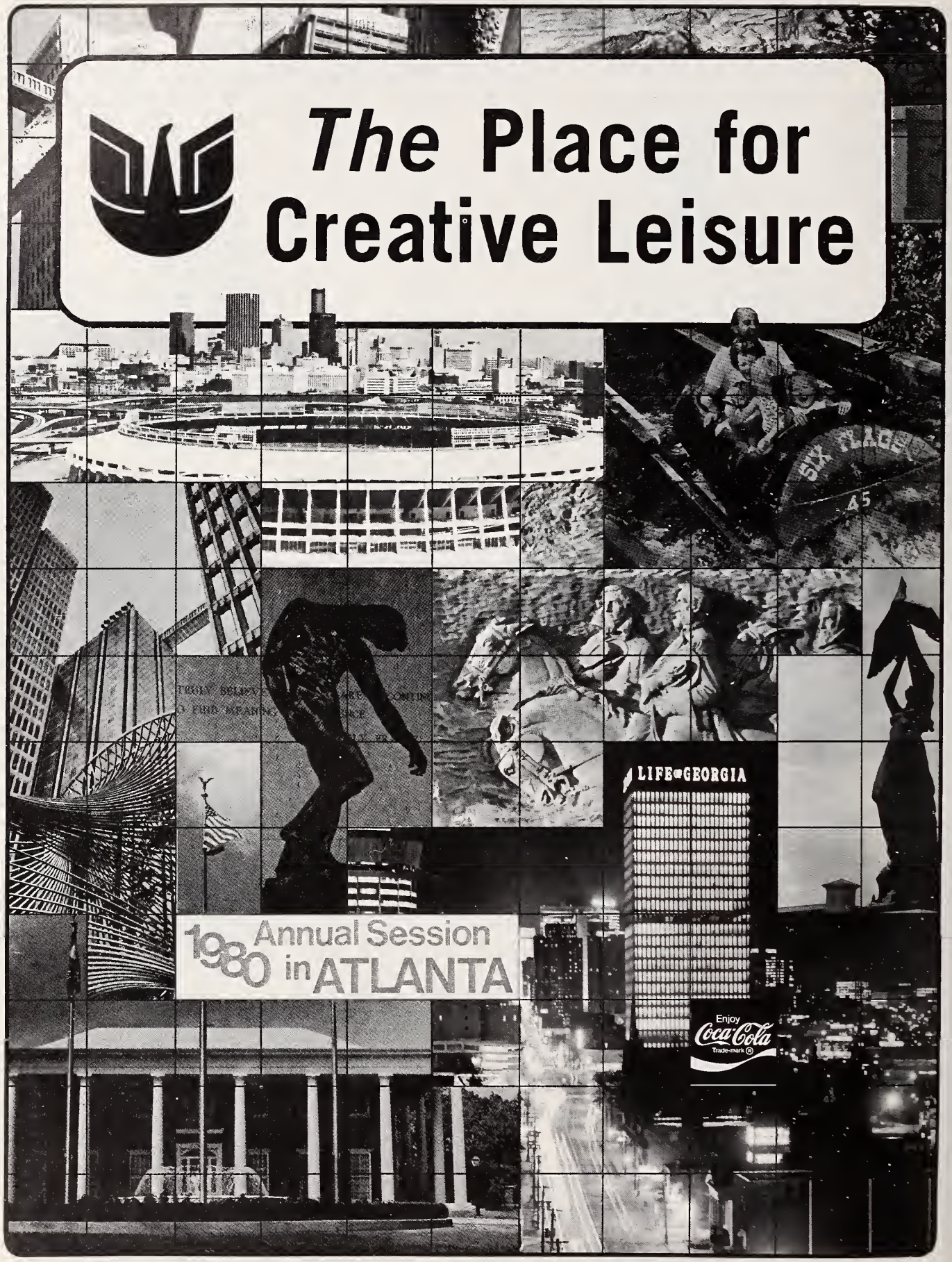
Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING


The Place for Creative Leisure
1980 Annual Session in ATLANTA
LIFE•GEORGIA
Enjoy
Coca-Cola
Trade-mark

JOURNAL
of the medical association of georgia

contents

VOLUME 69, NUMBER 4

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

ADVERTISING REPRESENTATIVE
Mary Coté

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
William R. Kenny, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D. Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
Earnest C. Atkins, M.D., Atlanta
President
H. Hilt Hammett Jr., M.D., La Grange
President-Elect
Carson B. Burgstiner, M.D., Savannah
Immediate Past President
Richard A. Griffin III, M.D., Cartersville
First Vice President
S. W. Clark, M.D., Waycross
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Stephen L. Daniel, Ph.D., Assistant Executive Director — Education
J. Tom Sawyer, Assistant Executive Director — Administration
Rusty Kidd, Director of Legislative Activities
Kenneth M. Williams, Director of Public and Professional Relations
Joyce Butler, R.N., Director of Medical Practice
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The Journal of the Medical Association of Georgia is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

284 Heat Injury: A Possible Association With Lithium Carbonate Therapy
David Lowance, M.D.
301 Gastric Bypass: New Relief for the Undesirable Side Effects of Jejuno-Illeostomy
Charles E. Wills Jr., M.D.

SPECIAL ARTICLES

264 Hospice: Care for the Terminally Ill
Robert Cowgill, M.D.
273 A History of Medicine in Atlanta and Fulton County, Georgia. Part I: Terminus to the Turn of the Century
Avalon Woodruff Bryant
281 1980 Medical Legislation Wrap-Up
James A. Kaufmann, M.D.
Rusty Kidd
293 "Health for All by the Year 2000": Can We Afford Such a Future?
John H. Bryant, M.D.

EDITORIALS

306 To Comfort Always
Edgar Woody Jr., M.D.
307 "Health for All" — Another Viewpoint
Harrison L. Rogers Jr., M.D.

FEATURE PAGES

313 Legal Page/State-Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgment
Thomas D. Harper
317 Cancer Page/Carbon Dioxide Laser in Gynecology
Matthew O. Burrell, M.D.

THE ASSOCIATION

320 President's Letter/I Had a Dream
Earnest C. Atkins, M.D.
321 New Members
321 Personals
322 Societies
322 Deaths

INCIDENTAL INTELLIGENCE

256 National Budget Highlights That Relate to Medicine
256 Report on the Status of MAG-Sponsored Insurance Retirement and Pension Fund
257 New Catastrophic Health Insurance Legislation Promises Substantial Savings
257 New Exhibition Opens at Atlanta Historical Society
258 Final Regulations Issued on Assignment of National Health Service Corps Personnel
258 Legislation Proposed to Reduce National Health Service Corps
258 Cobb County Annual Symposium — "You Are What You Think"
262 Medical Meeting Calendar

THE COVER

The featured article in this month's issue is the nascent Georgia Hospice Organization. The author describes how and why this organization was formed to meet the needs of terminally ill patients and their friends and family. In the early 18th century, Henry Fielding said, "It hath been often said that it is not death, but dying, which is terrible." Better, then, can we appreciate Dr. Cowgill's discussion of the necessity of new rubrics of care in dealing with the terminally ill, offering them not only honest and compassionate communication and understanding but also effective therapeutic palliation to alleviate the inevitable physical pain.

Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

National Budget Highlights That Relate to Medicine

The Carter Administration has asked Congress to approve a $61 billion budget for health programs, $5 billion more than last year, largely because of the climb in the costs of Medicare and Medicaid.

The budget for fiscal 1981, the year starting October 1, was marked by "overall fiscal restraint" due to the exigencies of inflation and international confrontations, but most health programs were ticketed for modest increases.

The Department of Health, Education, and Welfare asked for a total of $222.9 billion, of which $153 billion represented Social Security disbursements, and $51 billion was for Medicare and Medicaid outlays, up $5 billion.

The budget contained $326 million for support of health professions training programs, but states that by 1990 the supply will exceed the need, especially in the case of physicians. The termination of capitation grants to medical schools, a fiscal body blow to the schools, would be accompanied by a $77 million cut in support of nurse education. The budget provides a $17.7 million increase, for a total of $83.2 million, for expanded programs to train primary care physicians.

Support for direct health services in community health centers and migrant health centers would total $436 million, an increase of $54 million.

The budget for the National Health Service Corps (NHSC) would total $134 million, an increase of $52 million. This would swell the present Corps by 1,700, so that 4,500 health care professionals would be serving. At the same time, the NHSC scholarship program, with an additional $8 million, would be providing $94 million in support of 6,700 students who later would join the Corps.

Funds for the maternal and child health grants to states and family planning programs were set at $537 million, a $27 million increase.

A total of $565 million was earmarked for the Indian Health Service, a $50 million increase.

The administration is requesting $69 million — a $10 million increase — to support 36 new Health Maintenance Organizations (HMOs) and to expand 47 existing HMO plans.

The President's budget request for all mental health activities in 1981 is $671.3 million, including $367,775,000 for services, $162,964,000 for research, $90,354,000 for training, $12,117,000 for formula grants to states, and $38,113,000 for program administration.

The Medicare and Medicaid programs would be expanded. **Legislation will be sought to eliminate the Medicare requirement that beneficiaries be hospitalized for 3 days before they are eligible for home health care services.** Funds were proposed for a Medicare demonstration project to determine the costs and practicality of payment to home health aides for providing routine homemaker services, in conjunction with home health care.

The overall Medicare and Medicaid budget request for 1981 is $53.2 billion, an increase of $5.4 billion. The budget proposal includes $403 million to fund the Child Health Assurance Program (CHAP) now under consideration in the Congress. CHAP would extend health care to an additional 2 million poor children not now eligible for Medicaid.

Expanded services to migrant children and to poor children in urban areas would result from a proposed $90 million increase in the budget for the Head Start Program.

The budget targets $859 million for the Public Health Service to promote healthful lifestyles, provide preventive health services, and protect consumers and persons in the workplace, an increase of $87 million.

The National Institutes of Health budget is $3.6 billion, up $139 million. Only minor additional funds were sought for the 11 institutes. The National Cancer Institute continues to get the most, $1 billion, with Heart, Lung, and Blood next, at $548 million. *(Reported by the American Medical Association.)*

Report on the Status of MAG-Sponsored Insurance Retirement and Pension Fund

Following a thorough investigation by a consulting independent actuary in 1973, the Medical Association of Georgia (MAG) decided that the best insurance program it could provide its members was the one organized by the Southern Medical Association (SMA). The SMA program is in sound health, with an annual premium of $8.3 million and a premium stabilization fund of $3.8 million. Each line of insurance, including life, accidental death and dismemberment, long-term disability, office overhead, major hospital, and hospital indemnity, are favorably competitive with other organizational programs. Moreover, the Insurance Committee of the SMA is continually looking for ways to improve benefits or premium structure.

Insurance policies currently in force total more than $1 billion. In any type of group insurance sponsored by an organization, the key to success lies in two factors: participation and enrollment of incoming and younger members. A total of 11% of the insured members are under the age of 40, and in the past 6 months, 52% of the physicians and 26.5% of the premium dollars came from physicians under the age of 40.

A new major medical plan with four options ranging from a $250 to $1,000 deductible has been developed, providing a realistic surgical schedule and payment of all other medical fees at the 80% level. The program provides coverage up to $1 million. The term life insurance rates for the below 40 year age group have been recently reduced.

The retirement and pension program has now reached $42,000,000, and arrangements have been made to diversify the management of that money, with 25% being handled by Connecticut General and 75% by World Service. This arrangement was developed through the Insurance Committee for purposes of stability and diversification.

Because this insurance program is alive, well, healthy, growing, and competitive, it continues to justify the endorsement and participation of the MAG and its membership.

(Reported by William W. Moore, M.D., Chairman of MAG's Professional Liability Insurance Committee.)

New Catastrophic Health Insurance Legislation Promises Substantial Savings

Top House Republicans are now backing a new catastrophic national health insurance plan. House Minority Leader John Rhodes (AZ) and Rep. James Martin (NC), Chairman of the House Republican Task Force on Health Policy, say their Medical Expense Protection Act of 1980 is a two-pronged approach designed to improve health coverage under voluntary private plans and to provide catastrophic protection for all people not covered by a plan or by a public program.

A formula in the bill provides that once medical bills reach a certain percentage of income, all further expenses are automatically assumed by the program.

Estimated first year cost of the bill was set at $7 billion, compared to $24 billion for President Carter's health plan, and $50 billion for Sen. Edward Kennedy's approach.

Under the bill, private health insurance plans would be required to meet certain standards or lose their tax deductibility. The standards include minimum levels of catastrophic coverage, minimum employer premium contributions and certain types of coverage requirements.

"This approach, involving federal funds only when protection otherwise is not available, and only when expenses for a family are heavy relative to income, will entail less government intrusion and provide more benefits at lower costs than plans relying more heavily on government participation," Martin said.

Seventeen other house members have joined Rhodes and Martin in sponsoring the bill. A somewhat similar catastrophic plan is being considered by the Senate Finance Committee.

(Reported by the American Medical Association.)

New Exhibition Opens at Atlanta Historical Society



What were Scarlett O'Hara's real life contemporaries actually like? How were Atlanta women involved in the national issues of temperance, suffrage, and desegregation? How did Atlanta women dress for work, for meetings, and for dances? Atlanta women, their triumphs and traditions, step into the spotlight as the Atlanta Historical Society presents a major new exhibition, ATLANTA WOMEN FROM MYTH TO MODERN TIMES, currently being shown in the James M. Cox Gallery, McElreath Hall. This multi-faceted exhibition depicts the collective experiences of Atlanta women, both black and white, from the pioneer days of the 1840s to the post-war modernization of the 1950s. Their domestic, educational, cultural, organizational, and professional roles throughout Atlanta's history are portrayed through costume, photographs, and memorabilia. This represents the first comprehensive look at the accomplishments of local women since the renowned 1895 Cotton States and International Exposition held in Piedmont Park.

The exhibit is free and open to the public Tuesdays through Saturdays from 10:30 to 4:30, and Sundays from 2:30 to 4:30, in the Atlanta Historical Society's McElreath Hall, 3099 Andrews Drive, N.W., through January, 1981.

Final Regulations Issued on Assignment of National Health Service Corps Personnel

On February 27, the Department of Health, Education, and Welfare (DHEW) issued final regulations on requirements for the assignment of NHSC personnel to public or private nonprofit entities providing care to health manpower shortage areas. The regulations cover physicians, dentists, nurses, and other health professionals serving in the Corps. NHSC personnel must be assigned to serve populations in health manpower shortage areas. Organizations applying for Corps staff must meet strict requirements dealing with financial arrangements, reporting requirements, and other administrative procedures set forth in the Regulations.

The Regulations state that persons will be assigned to areas based on the probability that they will remain in an area once they complete their obligation to the Corps. The following criteria are used by DHEW in assigning these personnel: (1) the need of the health manpower shortage areas determined by federal law; (2) the use of physicians assistants, nurse practitioners, or expanded function dental auxiliaries as part of the NHSC project; (3) the willingness of individuals, government agencies, or health entities within the health manpower shortage area to cooperate with the National Health Service Corps in providing services; and (4) the comments of health professional societies serving the health manpower shortage area. These criteria are listed in descending order of importance in placement decisions according to the Regulations.

The Medical Association of Georgia (MAG) and DHEW staff in Georgia have agreed to use a standard form to obtain county medical society comments on NHSC projects. Officers of county medical societies should be prepared to comment on these projects when asked. Bert Franco, MAG's Assistant Director for Medical Practice, is available to work with county societies in responding to these requests for comments on NHSC projects. For a more definitive article regarding the Corps, refer back to the November 1979 issue of the *Journal of the MAG*. Extra copies are available. Contact the managing editor.

Legislation Proposed to Reduce National Health Service Corps

Senator Richard Schweiker (R-PA) has introduced a comprehensive health manpower bill that would sharply scale down the size of the National Health Service Corps (NHSC). The proposed legislation would phase down, over a 2-year period, the National Health Service Corps scholarship program to about one-third of its fiscal year 1980 level. "This program has, rather unfortunately I think, been expanded because of the demand for scholarship money for health professions students, rather than by a responsible assessment of the actual need for health professionals in nonmilitary service in 1985 and beyond," Schweiker said.

(Reported by the American Medical Association.)

Cobb County Annual Symposium — "You Are What You Think"

The 15th Annual Cobb County Symposium has been scheduled for April 17-18, 1980. Sponsored by the Cobb County Medical Society and the Cobb County Bar Association, the Cobb County Ministerial Association, and Kennesaw College, the Symposium will have as its main theme, "Thinking and Being: You Are What You Think."

Herbert Benson, M.D., Professor of Medicine at Harvard Medical School in Boston will speak on Thursday night, April 17, at Kennesaw College. He has written several books including "The Relaxation Response," and "The Body and The Mind." Bishop Arthur Vogel, Episcopal Bishop of the State of Missouri will speak on "Body Theology." The Reverend Robert Schuller from the Garden Grove Community Church in California will speak on "Move on to Possibility Thinking." Judge Ernst John Watts, Dean of the National Judicial College in Reno, Nevada, will also be a featured speaker.

For further information, write or call Symposium '80, Office of Community Services, Kennesaw College, Marietta, GA 30061, (404) 422-8770. Or call Mrs. Lily Grace Dozier, (404) 428-1039.

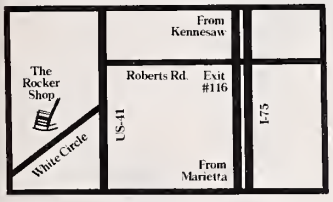
ROCKING THE NATION FOR OVER 100 YEARS...THE ONE AND ONLY BRUMBY ROCKER, ONLY AT THE ROCKER SHOP.

Few things have withstood the test of time as the Brumby Rocker. From it's early southern heritage, to today's White House, the Brumby has established a reputation as the world's finest handcrafted rocker. The moment production begins, to the moment we sell it to you, the Brumby is treated with the finest skill and care. The same skill and care used over 100 years ago when Brumbys were first made in 1875.

A Brumby Rocker is an investment in a future family heirloom. In fine homes throughout the country it has become a part of the family, rocking generations of children and a source of relaxation for all.

What gives the Brumby this enduring popularity? It begins with fine grained, solid oak which is half air dried and half kiln dried for natural expansion and contraction which helps prevent warping or bending. "Blue Tie" cane from Singapore is hand woven on both sides of the seat and back for comfortable cushioning and beauty from every angle. The steam bent back posts are curved to naturally cradle your back. The extra wide runners are designed with a slight rear arch to give an even rock and help prevent tipping. The man-size arms, with the original Brumby seal, let you rest your elbows comfortably. All are hand-sanded to a warm finish that accentuates the fine grained wood.

Good things are hard to find, but always well worth the search. If the Rocker Shop is a little out of your way, we'll gladly ship your Brumby Rocker anywhere. Major credit cards accepted.



The Rocker Shop of Marietta, Georgia

1421 White Circle, N.W. • P.O. Box 12
Marietta, Georgia 30061 • (404) 427-2618



Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

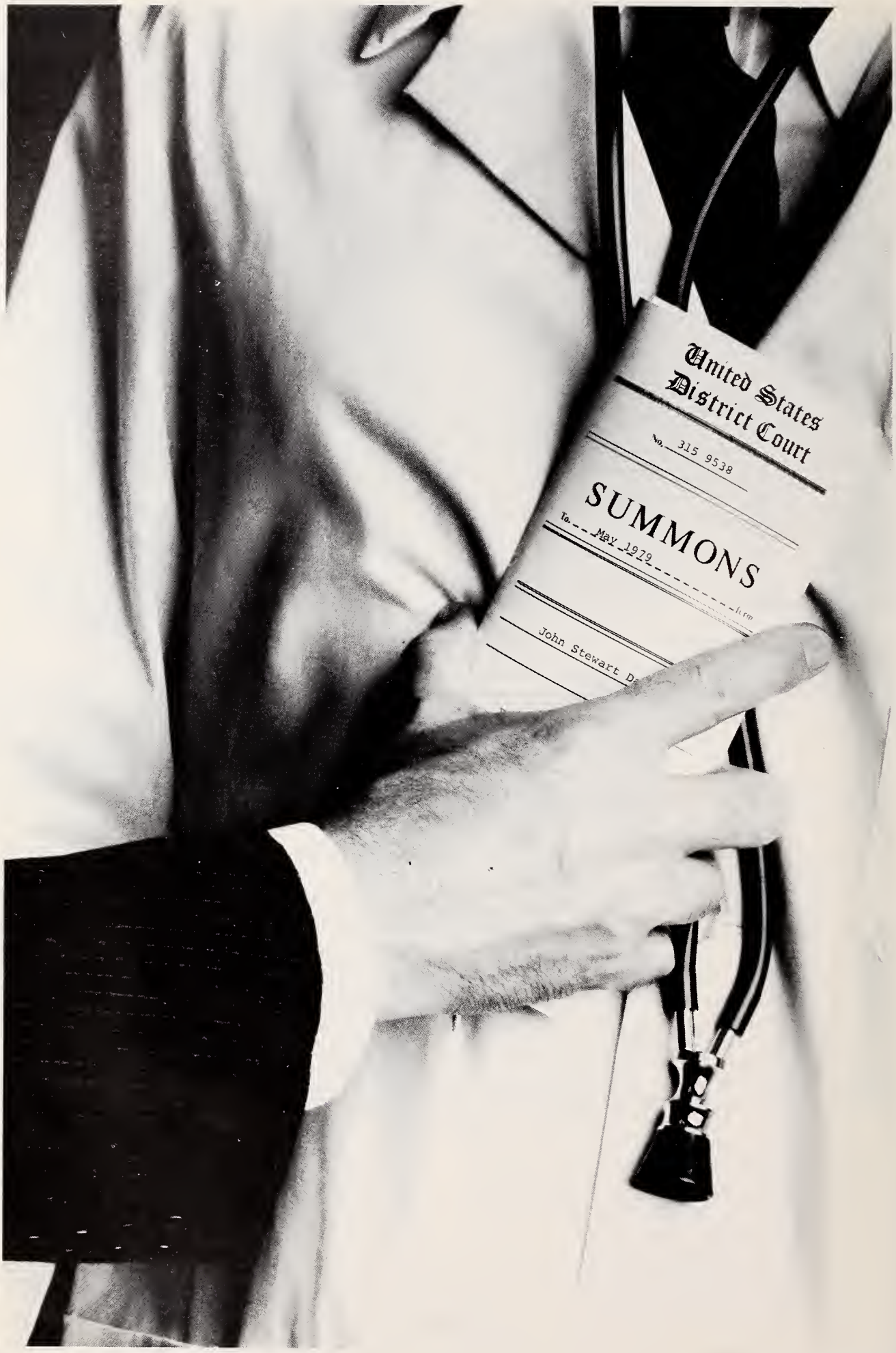
Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard


United States
District Court
No. 315 9538
SUMMONS
To. - - May 1979
John Stewart D

AFTER ALL THOSE YEARS OF HARD WORK, SOMEONE FINALLY HANDS IT TO YOU.

You're extremely vulnerable.

Because, along with achieving a good reputation, a nice-sized practice, and a large estate, you've become a prime target for malpractice claims.

And though you may get one that's of a frivolous nature, improperly handled it can cause enough pressure to affect you at work.

Which is why you may want to contact Insurance Corporation of America.

There are some specific reasons why we're better at helping you than other malpractice insurance companies.

AN ICA ATTORNEY. FROM THE START.

Legal action against a policyholder of ours is met head-on.

With legal action from us.

So, unlike other insurance companies, ICA doesn't give you a general adjuster who also handles auto liability claims.

Instead, even your initial phone conversation with ICA about a claim is with one of our licensed attorneys, seasoned in handling professional liability claims.

AFTER YOU CALL US, WE WON'T LEAVE YOU HANGING.

To help relieve the worries and frustrations a claim can bring you, we quickly become personally involved.

Soon after your call, we're discussing the claim face-to-face with you.

We also personally check every hospital record in a case, and act promptly on even a suspicion of a claim.

In so doing we're able to end many malpractice threats before they become formal suits.

And if a claim is formally lodged against you, your ICA attorney will bring together a task force drawn from the best, most experienced legal firms in the field of malpractice law.

He will coordinate the attorneys' efforts with those outstanding physicians who serve as ICA consultants.

And he'll be totally committed to fight until you get a favorable judgment or until all remedies by appeal or other proceedings are exhausted.

What's more, at ICA we never recommend that you settle just because it could be less costly than fighting.

WE TREAT $15,000-DOLLAR CLAIMS LIKE CLAIMS 100 TIMES BIGGER.

A small claim can do as much damage to a doctor's reputation as a big one.

And we're very sensitive to that fact. Because in addition to being operated by attorneys, our medical liability division is founded by an attorney who is also a physician.

So when it comes to protecting physicians, we're not only highly professional.

We're highly motivated.

And we hope that motivates you to fill in and mail the attached postage-paid form today.

ICA INSURANCE CORPORATION OF AMERICA

ICA Building, 2205 Montrose Blvd., Houston, Texas 77006, 713/526-4863

A:XV Reinsurance Protection Provided.

MEDICAL MEETING CALENDAR

APRIL

21-24 — *New Orleans, LA;* **61ST ANNUAL SESSION, AMERICAN COLLEGE OF PHYSICIANS;** Contact: JoAnn Plummer, ACP, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

24 — *Chattanooga,TN;* **MEDICINE REVIEW: GASTROENTEROLOGY;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

25 — *Atlanta;* **SECOND ANNUAL GASTROENTEROLOGY SEMINAR;** Category 1 credit; Contact: David M. Taylor, M.D., Program Chairman, Dept. of CME, Georgia Baptist Medical Center, 300 Boulevard, NE, Atlanta 30312. PH: 404/659-4211.

28-30 — *Atlanta;* **48TH ANNUAL ASSEMBLY, SOUTHEASTERN SURGICAL CONGRESS;** Category 1 credit; Contact: Southeastern Surgical Congress, 315 Boulevard, NE, Ste. 500, Atlanta 30312. PH: 404/681-3733.

MAY

1 — *Chattanooga, TN;* **MEDICINE REVIEW: RHEUMATOLOGY;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

1-4 — *Myrtle Beach, SC;* **SCMA ANNUAL MEETING;** Contact: South Carolina Medical Association, P.O. Box 1118, Columbia, SC 29211. PH: 803/252-6311.

5-10 — *Augusta;* **FAMILY PRACTICE SYMPOSIUM;** Category 1 credit; Contact: Glen E. Garrison, M.D., Director, Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

8 — *Birmingham, AL;* **SYMPOSIUM ON HEPATIC DISEASES;** Category 1 credit; Contact: Deena Metts, S. Highland Hosp., 1127 S. 12th St., Birmingham, AL 35205. PH: 205/251-0121.

7-9 — *Atlanta;* **TECHNIQUES IN ORTHOPAEDIC SURGERY AND MOTOR SKILLS WORKSHOP ON THE INTERNAL FIXATION OF FRACTURES;** Category 1 credit; Contact: Ronald G. Havican, Educational Coordinator, Ctr. for Rehab. Med., Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5535.

7-9 — *Savannah;* **1980 SOUTHEAST EMERGENCY MEDICAL CONGRESS;** Contact: R. T. Lowry, M.D., 901-D Kildaire Farm Rd., Carey, NC 27511. PH: 919/469-1942.

8 — *Chattanooga, TN;* **MEDICINE REVIEW: NEUROLOGY;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

8-9 — *Atlanta;* **CHRONIC PAIN: PROBLEMS OF MANAGEMENT;** Category 1 credit; Contact: Associate Dean of CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

9-10 — *Chattanooga, TN;* **INFECTION CONTROL;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

12-14 — *Atlanta;* **TRENDS IN CARDIOLOGY;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

15 — *Chattanooga, TN;* **MEDICINE REVIEW: DERMATOLOGY;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

15-16 — *Pine Mountain;* **EIGHTH ANNUAL PERINATAL MEDICINE CONFERENCE;** Category 1 credit; Contact: Division of Perinatology, The Medical Center, P.O. Box 951, Columbus 31902.

16 — *Gainesville, FL;* **A SYMPOSIUM: REFRACTING AND PRESCRIBING (OPHTHALMOLOGY);** Category 1 credit; Contact: Bill Rockwood, Office of CME, Univ. of Fla., Box J-233, JHM Health Center, Gainesville, FL 32610. PH: 904/392-3143.

22-23 — *Chattanooga, TN;* **ENDOCRINE DIAGNOSIS AND THERAPY FOR THE PRIMARY CARE PHYSICIAN;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

22-24 — *Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

24 — *Chattanooga, TN;* **NEW CONCEPTS IN DIAGNOSIS: MANAGEMENT OF DIABETES;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

30-31 — *Birmingham, AL;* **MKSAP: RHEUMATOLOGY, NEUROLOGY, GASTROENTEROLOGY, DERMATOLOGY;** Contact: Jaan Kangilaski, ACP, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

JUNE

5-7 — *Atlanta;* **EIGHTH ANNUAL HAND SYMPOSIUM: REHABILITATION FOLLOWING TENDON INJURIES;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

5-8 — *Chattanooga, TN;* **FAMILY MEDICINE REVIEW;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

12-13 — *Orlando, FL;* **STROKE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

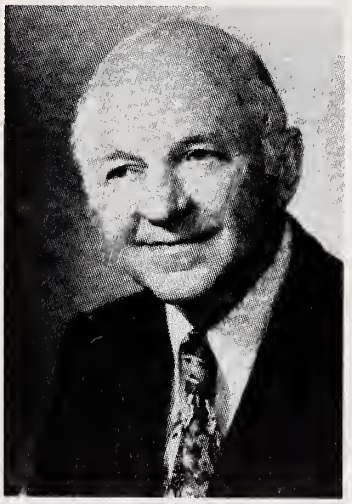
12-14 — *Jekyll Island;* **SELECTED TOPICS IN INTERNAL MEDICINE;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

13-15 — *Pinehurst, NC;* **EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

23-27 — *Lake Buena Vista, FL;* **MKSAP-V (INTERNAL MEDICINE REVIEW, ACP);** Category 1 credit; Contact: Bill Rockwood, Coordinator, Box J-233, JHM Health Ctr., Office of CME, Gainesville, FL 32610. PH: 904/392-3143 or 392-3183.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

medicard



I am proud to present the one card that increases your cash flow -- MEDICARD.

Whether your facility is a one person operation or a large health care group, we offer three day turnaround on your funds, less a minimal discount fee. In addition, we prepare tailor-made billing systems for your particular needs, and offer accounts receivable programs for your consideration.

As a provider of health care, you may offer to MEDICARD holders the opportunity to charge visits to your office, the hospital emergency room and outpatient clinics, prescriptions, eyeglasses and contact lenses, laboratory tests, wheelchairs, crutches and braces, hearing aids, physical therapy, convalescent and special health care -- anything and everything for good health.

MEDICARD was created to provide consumers with a line of credit for medical and health care expenses at a time when these costs are skyrocketing. We provide a substantial line of credit so that people do not have to dig into their savings or borrow to the limit of their bank credit cards.

Our research has shown there is a great need for these services. We stand ready to offer you, and the community, financial good health.

Here's to good health, for everyone, with MEDICARD.

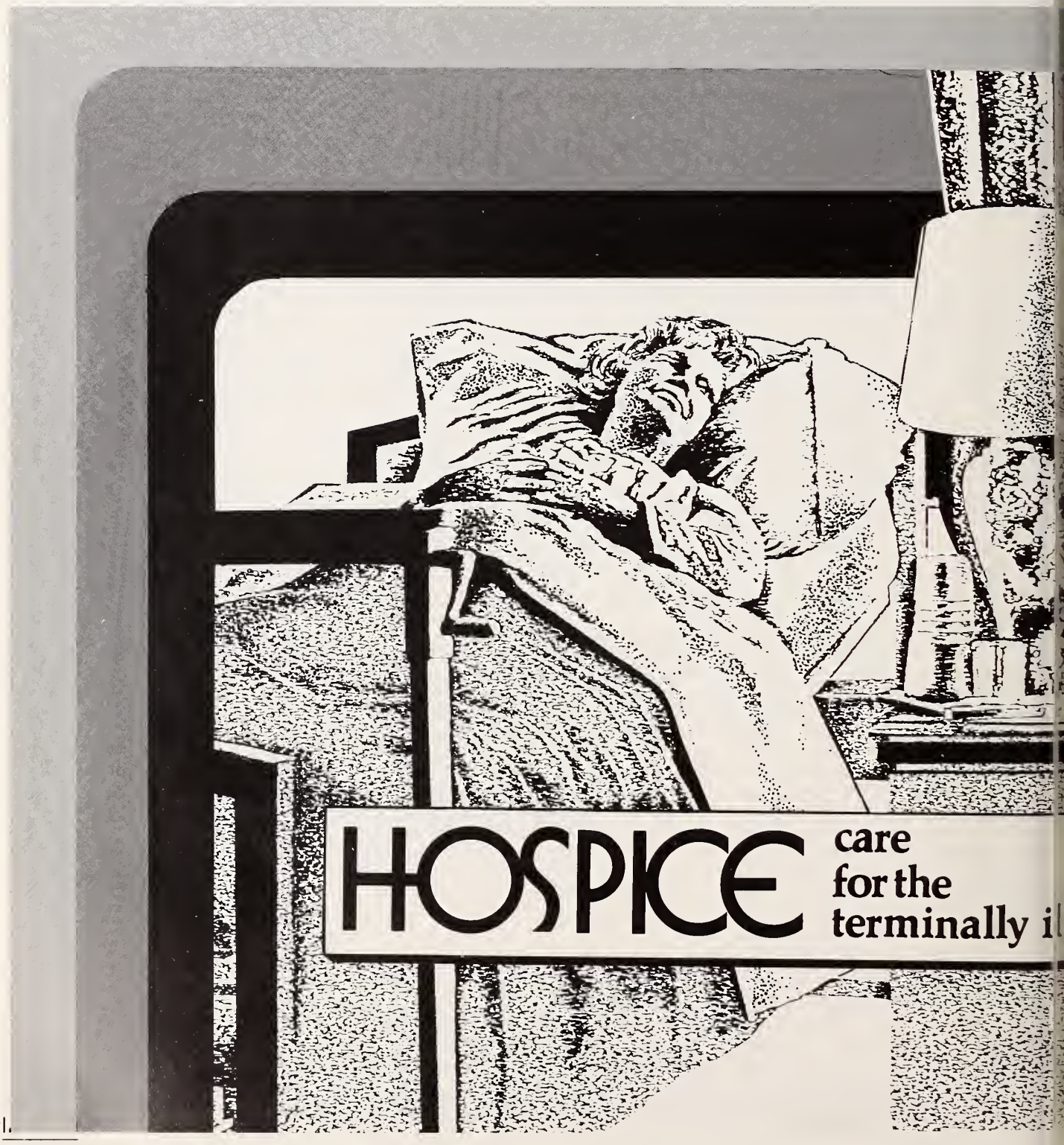
Sincerely,

Harold A. Dye, President

MEDICARD INCORPORATED
31 Executive Park Drive / P.O. Box 95329 / Atlanta, Georgia 30347 / (404) 325-2009

"The medical care of terminally ill patients should remain the responsibility of the primary care physician in order that maximal palliative care can be given while restoring continuity and stability to the dying process."

ROBERT COWGILL, M.D., *Atlanta**



* Dr. Cowgill is Medical Director of Hospice Atlanta, Inc., and practices oncologic surgery. His address is 960 Johnson Ferry Rd., Atlanta, GA 30342.

JOURNAL
of the medical association of
georgia

A good death does honor to a whole life.
Petrarch [1304-1374]
Canzoniere XVI

Many have studied to exasperate the ways of Death, but fewer hours have been spent to soften that necessity. . . . To learn to die is better than to study the ways of dying. Death will find some way to untie or cut the most Gordian Knots of Life, and make men's miseries as mortal as themselves.
Sir Thomas Brown [1605-1682]
Christian Morals, Pt. II, Sect. 13



THE GOAL of the hospice movement in Georgia is to improve the quality of life for terminally ill patients. Conscientious physicians have always done those things necessary to achieve this goal, and so it is only natural that they should assume a leadership role in the hospice movement. The movement in Georgia is dynamic. In January, 1980, five on-going hospice groups from three cities and other groups in the planning stages organized the Georgia Hospice Organization in Atlanta. These groups are developing a support structure for terminally ill patients which can be utilized by the doctor to assist him in implementing his or her medical care plan. In most cases, home care can be provided by the family and friends with the support of the hospice volunteer and organization. Good symptom control and a progressively improving quality of life can be achieved at a fraction of the cost of the alternatives.

Why Has the Hospice Movement Emerged Now?

As our society has evolved in the last 80 years, many forces have coalesced to result in the need for a hospice movement. At the turn of the century, many Americans were living in large multi-generation houses with close and longstanding ties to their neighbors and family. Whenever one of them became terminally ill there was a ready-made support system, with the doctor and minister calling as needed. Diseases generally ran their natural courses, and there were no medical institutions or structured second opinions. Also, patients tended to be more resigned and accepting than today.

The urbanization of our society over the intervening 8 decades has brought many changes. We have moved away from our parents and siblings and have a far-flung network of close friends and are generally not well acquainted with our neighbors. Medical care has become more institutionalized and depersonalized, and this has contributed to the patient's sense of isolation, helplessness, and despair. The hospice movement identifies people who are inclined to come to the aid of the dying in their community, educates these volunteers to maximize their effectiveness, and supports them with an interdisciplinary team so that the physician's medical care plan can be implemented more effectively. In doing this, the negative isolating effects caused by our urbanization and socialization process can be reversed, and all of the parties involved can once again experience the sense of well being that results when we belong to a caring, loving community.

The Georgia Hospice Organization

On Oct. 14, 1979, representatives from Atlanta, Columbus, Savannah, Athens, and Augusta hospice groups agreed to form a state organization to potentiate the growth of the movement. On Jan. 13, 1980, articles of incorporation were drawn up, and officers were elected. Reverend Vernon Grambling of Grady Hospice, Inc., in Atlanta was elected president. Table 1 lists the contact people for the various groups. All Georgia physicians are encouraged to become involved with their local movement or help initiate one. Florida, California, Kentucky, and New York have preceded us in forming state organizations and have promoted state legislation to insure quality hospice standards.

Acceptance by the Medical Community

Each hospice developing in our state has enjoyed the support of its respective medical community.

TABLE 1 — Who to Contact in Georgia Hospices

Hospice Organization	Level of Care Given	Address	Contact Person
Grady Hospice, Inc.	In-patient and home care	80 Butler St. Atlanta, Ga. 30303 (404) 588-4885	The Rev. Vernon Gramling (same address and number)
Hospice Atlanta, Inc.	Home care	5665 Peachtree Dunwoody Rd. Atlanta, Ga. 30342 (404) 256-7271	Marea Jo Bickley, Pres. 460 Forest Valley Rd. Atlanta, Ga. (404) 255-8527 Robert Cowgill, M.D. (404) 256-3232
Hospice of the Good Shepherd	Home care	374 W. Ponce de Leon Ave. Decatur, Ga. 30030 (404) 377-6474	L. C. Buchanan, M.D. (same address and number)
Hospice Savannah, Inc.	Home care	P.O. Box 23015 Savannah, Ga. 31403 (912) 236-1182	Anne Stewart, Pres. 1603 Foxhall Rd. Savannah, Ga. 31406 (912) 355-1614
St. Joseph Hospital Home Health Care and Hospice	Home care	1600 Winter St. Augusta, Ga. 30904 (404) 733-7791, Ext. 363	Sister Rose McLarney Asst. Admin. of Outreach Services (same address and number)
		Not Yet Operational	
Columbus Hospice, Inc.	Planning to offer home care	6758 Standing Bay Rd. Columbus, Ga. 31904 (404) 327-4217	Dale Jernigan (same address and number)
Athens, Georgia	Planning to offer home care	670 Jefferson River Rd. Athens, Ga. 30607 (404) 543-1984	Angela Lain (same address and number)
Wesley Woods Health Center	Planning to offer in-patient	1841 Clifton Rd., N.E. Atlanta, Ga. 30329 (404) 325-2988	Robert L. Brown, M.D. (same address and number)

The Medicine and Human Values Committee of the Medical Association of Georgia studied the movement and arranged for an educational display featuring hospice at the annual Scientific Assembly in Atlanta in November, 1979. Likewise, the Medical Association of Atlanta has been supportive of Hospice Atlanta, Inc. The movement in our state has never been anti-medical and requires that the primary doctor/patient relationship remain intact throughout the terminal illness, with the original physician becoming the hospice physician with the resources of the organization at his patient's disposal.

Treatment Modalities

Many Georgia physicians have followed the lead of the hospice organization in England and are prescribing Brompton's solution for their terminally ill patients. The main ingredient is morphine sulfate, which used to be thought of as being poorly absorbed from the gut. Experience has shown, however, that absorption is predictable and reproducible, with dosages ranging from 10 mg. to 40 mg. being adequate to control the pain if administered on a round-the-clock basis every 4 hours. Many physicians find that cocaine, when added to the mixture, serves as a mood elevator. A common formulation would include 2000 mg. of morphine, 500 mg. of cocaine, with an alcohol base sufficient to make one liter of solution, so that one teaspoonful (5 cc) would contain 10 mg. of morphine. The patient keeps the bottle at his bedside and is encouraged to take a dose every 4 hours so as to never allow the pain to recur. Respiratory depression has not been a problem.

Reimbursement for Hospice Services

Hospice services are currently donated by an all-volunteer staff, and no charges are made. As a larger percentage of terminally ill persons are reached, however, salaried personnel will be necessary to administer and co-ordinate the programs. Grants and donations are being sought to help defray these expenses initially, and in the future it is expected that third party payors will reimburse the various hospices for services. Medicare and Blue Cross/Blue Shield are conducting demonstration projects to determine the cost-effectiveness of hospice services, and the General Electric Corporation has led the way

as the first major company to offer "hospice benefits" in its employee health care benefit package.

In-patient Hospice Care

While home care is appropriate for the majority of terminally ill patients, a small percentage will have symptoms that cannot be controlled at home. Our hospitals have served the needs of these patients in the past, and many have made adjustments and improvements in recent years to address themselves to the specialized needs of dying patients. While only one of the hospice groups functioning in Georgia presently has in-patient capability, data are being collected from those that are operational around the country to compare free-standing terminal care facilities with those functioning as departments in acute care hospitals. It is not clear which of these two models is best, but common elements of successful hospice facilities include:

a. The environment is more home-like than hospital-like, and is located with reasonable proximity to the patient's own home.
b. Emphasis is placed on augmenting and encouraging the family and friends support group to combat the natural tendency to withdraw from and isolate the dying individual.
c. The patients are encouraged to be in charge of their dying process with all the facts of the illness carefully explained to them so that intelligent decisions regarding their treatment might be made.
d. The patients are segregated from the acute care patients so that the paging system, alarms, bells, and disruption of sleep for monitoring vital signs will not adversely affect the quality of life.
e. The terminal care is cost-effective relative to care with a hope of cure.
f. Primary attention is paid to adequate symptom control.

A Look Into the Future

As the hospice movement grows and a greater percentage of the general population is made up of hospice volunteers, many of the social taboos with regard to the dying process will inevitably disappear. The main long-term benefit will be a heightening of awareness and consciousness in regard to handling such loss, and psychosomatic illnesses should decrease noticeably. Hospice in-patient facilities will be appearing initially as specialty areas in our acute care hospitals and nursing homes. As experience accrues in these facilities and in the free-standing models, it will become more clear as to which type of facility is best in a given setting. The physicians in our state will have a community based support system available to them to help to overcome the thorny disposition problems that frequently accompany terminal illness. The medical care of terminally ill patients should remain the responsibility of the primary care physician in order that maximal palliative care can be given while restoring continuity and stability to the dying process.



The transition between life and death should be gentle in the winter of life. Death, under these conditions, is invested with a certain grandeur and poetry, if it comes to a man when he has completed his mission. . . . There is nothing to fear, nothing to dread.

Rudolph Matas [1860-1957]
The Soul of a Surgeon

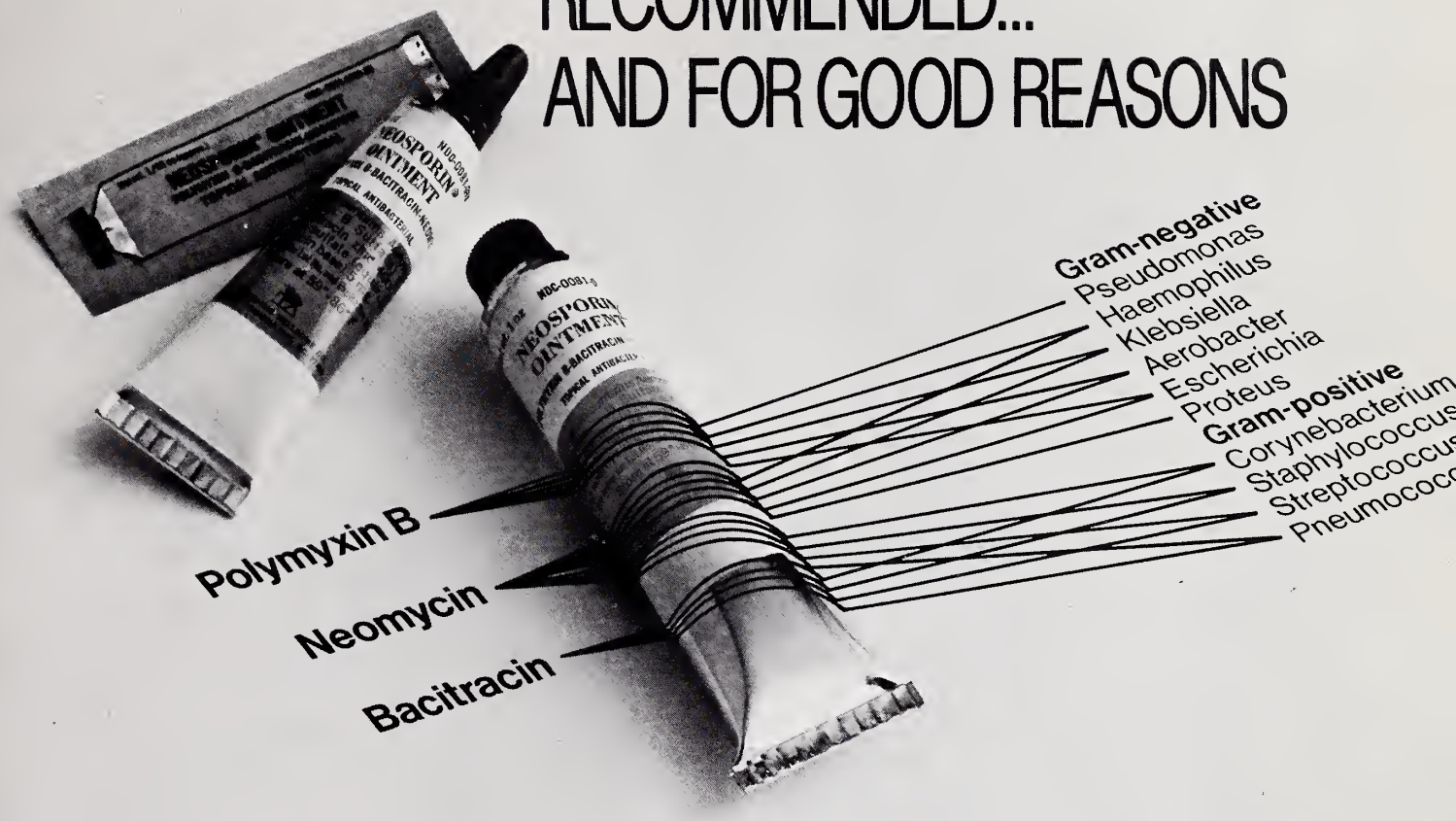
Morris E. Chafetz, M.D.,
Founding Director of the National
Institute on Alcohol Abuse and Alcoholism,
is pleased to announce
the opening of a private
residential alcoholism treatment facility
in Charleston, South Carolina.



FENWICK HALL

John H. Magill, Executive Director. Layton McCurdy, M.D., Medical Director. Phone 803-559-2461.

IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
2. helps prevent topical infections, and treats those that have already started
3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically
5. you can recommend it in any of the three convenient package sizes: 1 oz tube, ½ oz tube, or the versatile, single-use foil packet



selected by NASA for the Apollo and Skylab missions

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Perdiem™

empties the bowel gently...

by filling it.

Perdiem™ . . . the re-educative laxative . . . relieves constipation by a unique combination of physiological bulk stimulus and gentle pharmacologic encouragement of peristaltic response.

ROHRER

WILLIAM H. RORER, INC.
Fort Washington, PA 19034



Made in West Germany

(Please see next page for prescribing information)

Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

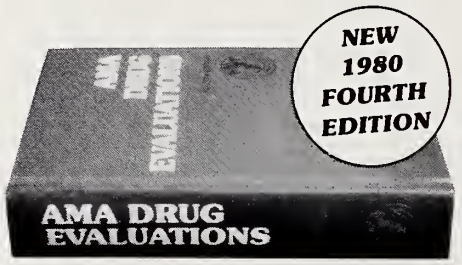
HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

ROER

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

NOW AVAILABLE!

The most useful and definitive book on drug therapy!



Completely reorganized, updated, and expanded, *AMA DE/4* is the most inclusive, comprehensive, and objective drug compendium ever assembled, covering virtually every significant drug prescribed in the U.S. today. Over 1,300 drugs are evaluated, including 57 new drug listings.

An indispensable, clinically-oriented guide for prescribing, dispensing, or administering drugs

Organized by therapeutic category, each chapter begins with an introductory overview, followed by detailed evaluations for individual drugs. *AMA DE/4* gives information on dosage, actions and uses, and contraindications-plus a listing for hundreds of additional mixtures and proprietary preparations.

THE authoritative guide

You can be confident the information is accurate and clinically pertinent because it was compiled by the AMA Drug Department working with the American Society for Pharmacology and Therapeutics and a consulting panel of more than 300 distinguished physicians and other health care professionals.

Order AMA DE/4 today!

Order Dept., OP-075, AMA
P.O. Box 821, Monroe, WI 53566

50% discount for Residents! Only $24!

Please send me_____copy(ies) of **AMA Drug Evaluations, 4th Edition,** OP-075. $48 per copy. (Residents, $24). Enclosed is my check, payable to AMA, for $ _____. Payment must accompany order. If Resident, indicate hospital below.

Please print SJ

Name _____

Hospital _____

Address _____

City _____

State/Zip _____

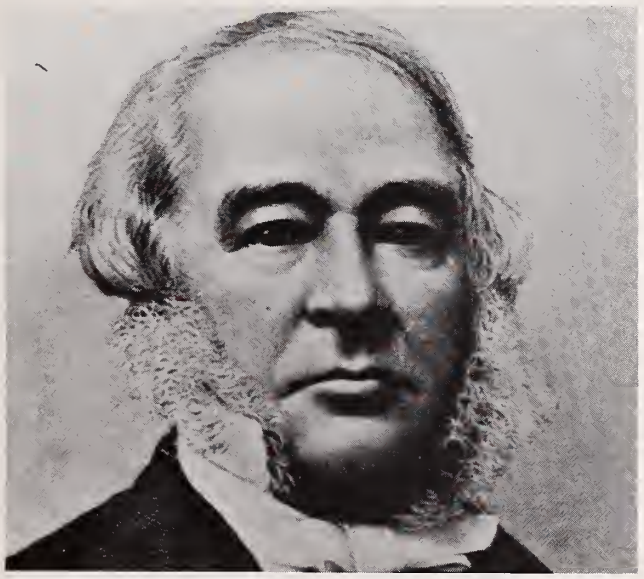
If the science of medicine is not to be lowered to the rank of a mere mechanical profession, it must concern itself with its history.

Littré

A History of Medicine in Atlanta and Fulton County, Georgia.

Part I: Terminus to the Turn of the Century

AVALON WOODRUFF BRYANT, *Atlanta**



This man named Atlanta. JOHN EDGAR THOMSON, born in Pennsylvania in 1808, came south in 1834 as Chief Engineer of the Georgia Railroad. This line was completed from Augusta to Marthasville in 1845. Soon after suggesting the coined word, Atlanta, in lieu of Marthasville, he returned to his native state. The name of Atlanta was not duly recognized and legalized by the Legislature, however, until December, 1847.



Atlanta was once named for MARTHA LUMPKIN COMPTON (1827-1917), daughter of Georgia governor Wilson Lumpkin. Her name inspired the first official name of Atlanta, Marthasville, 1843-1845. Prior to 1843, the village at the southern terminus of the Western & Atlantic Railroad was known informally as Terminus.

(Both photos courtesy of the Atlanta Historical Society.)

Introduction

THE INTRIGUING STORY of medicine in the area now encompassed by Fulton County, Georgia, does not begin simply with the formation of the county in 1853. One must look back farther in historical records to discover the roots of medicine in Fulton County and something of its pioneer doctors. Many of these men of medicine played a vital role in the early development of the area, and a history of medicine would not be complete without a brief review of the events and accomplishments of those early days.

In the Beginning

In 1835, Governor Wilson Lumpkin determined that Georgia should participate in a railroad building project. Accordingly, late in 1836, the Georgia legislature authorized the construction of a railroad at state expense. In the following year, Colonel

* Mrs. Bryant is married to Milton F. Bryant, M.D., an Atlanta surgeon. She is Past President of the Auxiliary to the Medical Association of Atlanta, Past President of the Auxiliary to the Medical Association of Georgia, and currently on the Board of the Southern Medical Association Auxiliary. Her address is 3569 Dumbarton Rd., NW, Atlanta, GA 30327. This paper was presented to the Atlanta Historical Society in 1977.

Stephen H. Long, a career Army officer, was retained by the state to make a survey and build the road. As a result of his efforts, the legislature authorized the railroad to be constructed from the Etowah River south to Montgomery's Ferry at Standing Peachtree on the Chattahoochee River and then south "— to some point not exceeding eight miles, as shall be most eligible for running branch roads."[1] The railroad junction point and terminal was located just to the west of the Peachtree-Sandtown intersection. This area was known as Terminus.

At this time in the history of the area, there were no resident physicians and in order to obtain medical care, the early settlers had to travel either to Marietta or to Decatur. Terminus' first baby, Julia Carlisle, was actually born in Marietta, as her mother was taken via stagecoach to that city for the birth.[2]

As the railroads completed new lines from Chattanooga, Augusta, Macon, and Savannah, the little settlement grew rapidly. In 1843, Terminus was renamed Marthasville in honor of Governor Lumpkin's youngest daughter. The name Atlanta was chosen 2 years later, since it was felt that the name Marthasville was too provincial for the booming young settlement. However, it was not until December, 1847, that the new name was legally recognized by the state legislature.

The First Physician

In 1845, the profession of medicine became permanently represented in Atlanta in the person of Dr. Joshua Gilbert. Dr. Gilbert was born in Clemson County, South Carolina, in 1815, and arrived in Atlanta shortly after his graduation from the Augusta Medical College in 1845. After settling into the bustling community, he met and married his first wife, Elizabeth Humphries, daughter of the proprietor of the famous White Hall Tavern.

A great deal has been written about Atlanta's first physician. He was a young man when he began ministering to the medical needs of the 200 or so members of the pioneer community, and it was not long before his name became a byword in that part of Georgia. He was a typical example of a doctor of the old school, not extensively learned in the science of medicine, but knowing a great deal about the art of medicine. He had a priceless asset in his intimate familiarity with human nature, and his patient's trust in him brought out the best he had to offer.

Sometime after his arrival, Dr. Gilbert built an office on Marietta Street between Broad and Forsyth Streets. From the stories told of Dr. Josh, however, it is doubtful that the office was used very frequently. His biographers tell of him most often on horseback or traveling in a small sulkey, carrying his medicines and equipment in a pair of saddle bags. As he traveled around the area, Dr. Gilbert blew a whistle to let prospective patients know that he was available and would probably not pass that way again that day. He kept no books and rarely presented a bill, yet he prospered modestly. Before the end of 1845, Dr. Gilbert had competition in Atlanta, for in December of that year another young doctor was attracted to the thriving community. He was Stephen Terry Biggers, a native of Abbeville District, South Carolina, and a graduate of the Macon College of Medicine. Dr. Gilbert and Dr. Biggers shared the practice for about 2 years.

Dr. Joshua Gilbert became one of the most beloved of the early settlers of Atlanta, and his friends were many. He was a member of Atlanta's first Board of Health and continued to practice in the city until the Civil War. He then moved to the old family home on Sandtown Road at Cascade Springs, where he spent the remainder of his life. Dr. Gilbert died in 1889 and is buried in the cemetery at Utoy Church. The epitaph on his grave marker is one which might well be suitable for many a busy physician.

I will soon be in Heaven
and it will be Rest! Rest!
Sweet Rest for me.

Dying words of
DR. J. GILBERT.

'The Beloved Physician'
A Devoted Husband,
An Affectionate Father,
A Faithful Friend,
An Earnest Christian.
Born Sept. 17, 1815.
Died April 18, 1889.

'Peaceful be thy silent slumber
Peaceful in the grave so low.'[3]

New Faces, New Challenges

Early in January, 1849, Dr. Benjamin Bomar took office as Mayor of Atlanta. Dr. Bomar was Atlanta's second mayor and had previously practiced medicine in Dahlonega, Georgia. After arriving in Atlanta en route to Texas, he became enamoured with the bustling town and its people. He changed his traveling plans and made Atlanta his home. He was one of the first physicians in town to take an active part in politics, and he became an outstanding leader. He was also a founder of the Second Baptist Church. In the year following his term as mayor in 1850, Dr. Bomar served on the Board of Health with Julius A. Hayden and Dr. J. F. Alexander. It is interesting to note that a resolution was passed authorizing the new mayor to sell the hospital if its original cost could be obtained. In case we might jump to conclusions about the excellent state of health in Atlanta, it must



THE SOUTHERN MEDICAL COLLEGE as it looked at the turn of the century. Atlanta was assuredly in the forefront of offering quality medical education in the South at that time. (Photo courtesy of the Atlanta Historical Society)

be added that later in the year it was proposed to exchange the hospital for a graveyard, "sufficiently large to meet all requirements."[4]

The 1850 census in Atlanta shows a total of eight physicians as residents in the community.[5] The 1850's witnessed the construction of several noteworthy houses along Peachtree Street. One of these was constructed at the southwest corner of the Market (later Broad), Luckie, and Peachtree Street intersection. The two-story structure, which was one of the first brick residences in Atlanta, was built in 1851 for Dr. Crawford Williamson Long, who achieved fame as the first person to use anesthesia successfully in a surgical operation. After living there only one year, the distinguished physician moved with his family to nearby Athens, and Atlanta lost a prominent resident.

The early history of Atlanta and Fulton County contains many names of early physicians. Beginning in 1929, the Bulletin of the Fulton County Medical Society published a series of biographies on some of these early, renowned men.

Fulton County was organized in 1853. The growth of Atlanta into a city of relatively commanding importance made it necessary to form a new county with Atlanta as its seat of government. The territory for this new county was taken from the county of DeKalb. Information on the order of creation of Georgia's counties from the State Archives shows that beginning with the Creek and Cherokee cessions, the land upon which Fulton County stands was formerly occupied by 12 other counties, 10 of which exist today.[6] There has been some disagreement as to the naming of the county. Some authorities feel that it was named for the inventor of the steamboat, Robert Fulton. Others feel that it was named in honor of Hamilton Fulton, a civil engineer, who surveyed the land for the Western and Atlantic Railroad. It is generally conceded, however, that Robert Fulton is the most likely individual for whom the county was named.

Some Giant Steps in Medical Education

The City of Atlanta took three steps forward during 1854-1855 in the direction of becoming a medical center. The three steps represented the establishment of the Atlanta Medical College, the Atlanta *Medical and Surgical Journal,* and the first medical society, known as the Brotherhood of Physicians. The College and the Society were formed by Dr. John G. Westmoreland, and the *Journal* was started by J. G. Westmoreland and his younger brother, Dr. Willis F. Westmoreland. Also, the first Fee Bill and Code of Ethics was published the same year. The Fee Bill of 1854 indicates that the price of a visit in the city was $1.00 in the daytime and $2.00 at night.[7] This document was signed by 14 physicians, who might be called the "Apostles of Atlanta Medicine." They were:

N. D'Alvigny, M.D.	Hayden Coe, M.D.
James F. Alexander, M.D.	J. G. Westmoreland, M.D.
H. A. Ramsay, M.D.	W. T. Grant, M.D.
Josiah A. Flournoy, M.D.	B. M. Smith, M.D.
T. C. H. Wilson, M.D.	Thomas Denny, M.D.
Joshua Gilbert, M.D.	H. Westmoreland, M.D.
N. L. Angier, M.D.	T. M. Darnell, M.D.

It was in 1853 that a small group of enthusiastic doctors, headed by Dr. John G. Westmoreland, conceived the idea of founding a medical school in

Atlanta. A charter was applied for and granted by the legislature on Feb. 14, 1854. The first session of the college was from May to September, 1855, with lectures being held in the City Hall. The lectures of the first session ended on Aug. 28, 1855. On Sept. 1, 1855, the first degrees of doctor of medicine were awarded to 31 graduates.[8]

During 1855, while the Atlanta Medical College was conducting its first term, the city also acquired its first privately operated infirmary or hospital. Its opening was announced in the following advertisement that ran in the *Atlanta Intelligencer* and the *Cherokee Advocate* at Marietta.

Infirmary

"The undersigned have opened, in the City of Atlanta, an Infirmary for the reception of patients laboring under medical or surgical disease.

"An intelligent nurse and faithful servants will be in constant attendance and will give their attention to the sick at all hours, day and night, when required.

"The surgical department will be under the control of W. F. Westmoreland, who will give prompt attention to injuries and every variety of disease requiring surgical operations. The usual fees adopted by the physicians of the city will be charged with 15 cents per day for board, etc.

"Planters and others sending negroes may rest assured that they will be properly attended to, and if after an examination it be determined that there is no prospect of relief, they will be sent home without any charge.

W. F. Westmoreland, M.D.
J. G. Westmoreland, M.D.
Atlanta, April 24, 1855"[10]

In the years from 1860 to 1866, the functions of the medical college were interrupted by the Civil War. However, in 1866, the school graduated 35 doctors. The following year, in 1867, there began a steady decline in the fortunes of the medical college, coincident with the era of reconstruction.

It was not until 1879 that another medical school arrived on the Atlanta scene. It was at this time that the Southern Medical College began its career. The college prospered, its attendance increased, and its graduates became men of influence in the profession throughout the South.[9] In 1898, the two medical colleges — the Atlanta and the Southern — were merged into a single institution called the Atlanta College of Physicians and Surgeons, and this, in turn, some 20 years later, became the Medical School of Emory University.

The Beginnings of Organized Medicine

In 1854, 7 years after Atlanta was incorporated as a city, organized medicine had its beginning in Fulton County. It is of interest to note the first group was christened the Brotherhood of Physicians, but it soon changed the name to the Atlanta Medical Society. All of the early records were destroyed during the Civil War, but it is known that meetings were suspended during that time.

In 1865, the post-war medical society was organized as the Atlanta Society of Medicine. According to Dr. Frank Boland's account, "But soon there was a rival organization, the first Fulton County Medical Society, and much bitterness was engendered between the two factions, the only schism which marks our record. Fortunately, however, harmony was restored in 1872, when the two groups consolidated as the Atlanta Medical and Surgical Union. A year later the name was changed to the Atlanta Academy of Medicine.

"Fifteen years after the burning of Atlanta, though the Academy had less than 50 members, it was ambitious enough to be host to the American Medical Association for the 1879 session. The meetings were held in De Give's Opera House, a new theater of which the city was very proud. Dr. J. P. Logan, the organization's first president in 1855, gave the address of welcome.

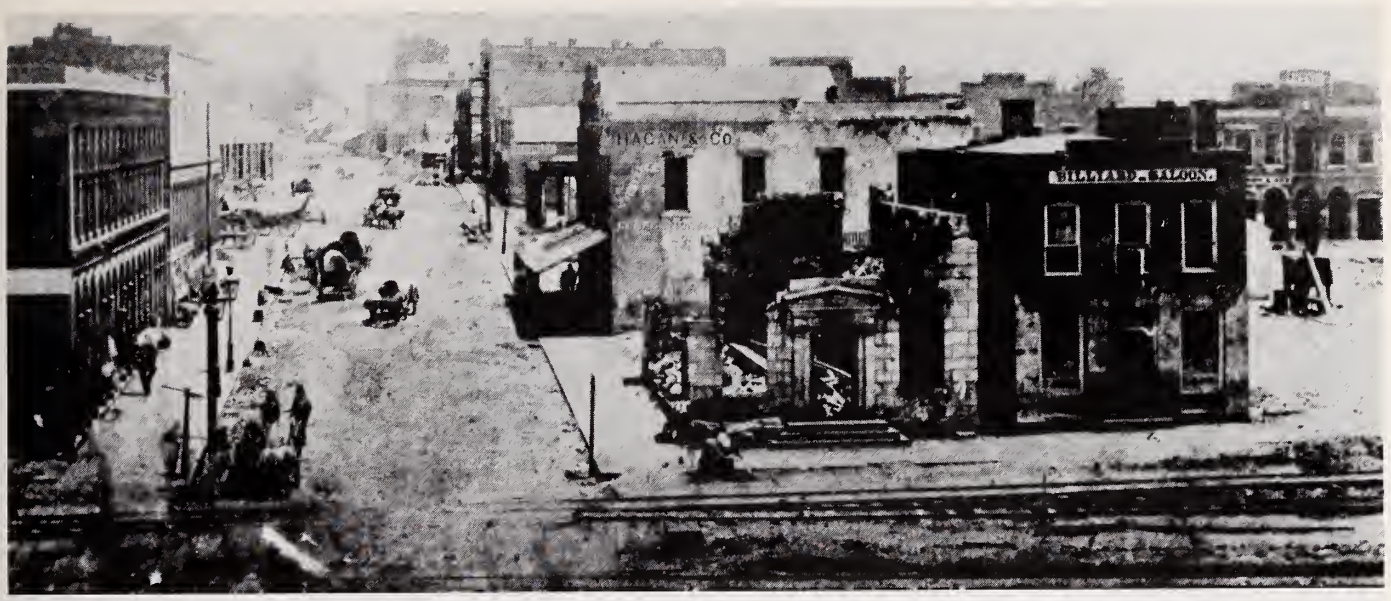
"The name of the organization was changed again in 1885 to The Atlanta Society of Medicine."[11]

Effects of the Civil War

Atlanta's forward march of progress and prosperity was stayed by the outbreak of the Civil War in 1861. Following Georgia's secession from the Union in January of that year, the residents of Atlanta and Fulton County concentrated their efforts and enthusiasm upon helping the South to emerge victorious.

On June 1, 1862, Atlanta was made a military post. By the middle of that summer, there were a number of Confederate hospitals in the city — the Empire, the Heery Hospital, Gate City, City Hotel, Alexander, Concert Hall, Wilson's, Denny, Medical College, Jane's, Haydens and, of course, Fairgrounds I and II.[12]

The coming of the great, destructive Civil War made radical changes in the lives of the citizens of Fulton County. Insofar as the medical community was concerned, the medical college was no longer graduating new doctors, the medical society had suspended its meetings, and the doctors of the vicinity either found themselves in the Confederate medical service or serving at the numerous hospitals in the area. The women of Atlanta formed relief and aid societies, the businessmen geared their operations to wartime needs, and ads such as the following appeared in local newpapers. This one is from the June 3, 1862, issue of the *Daily Intelligencer:*



PEACHTREE STREET looking north from railroad crossing, 1865: The combatants had gone, but the ruins of the war remained, such as the classic facade of the Georgia Railroad Bank, center foreground. The vacant property to the right of the billiard saloon had been the site of the Atlanta Hotel. Five years later, it was improved by the first Kimball House. The new National Hotel, left foreground, is now the site of the First National Bank Tower. (Photo courtesy of the Atlanta Historical Society.)

CALHOUN'S PILLS

Owing to the blockade
Medicines have become extremely
SCARCE
We have contracted with
DR. E. M. CALHOUN
For all of his celebrated
FAMILY PILLS

As no more can be made while the blockade lasts, Families will do well to supply themselves now.

Retail Price, 75 cents per Box

A liberal discount to Dealers. Reference is made to high testimonials contained in the handbills.

HAMILTON, MARKLEY & JOYNER[13]

When news of the secession of Virginia reached Atlanta on April 18, 1861, enthusiasm knew no bounds. On the following day, however, as thoughts became more realistic, a committee of safety was organized whose duty it was to care for the families of those who had volunteered to serve in the armies of the Confederacy. On April 27, a number of Atlanta physicians tendered their services gratuitously to the destitute families of citizens who had engaged in the military service of the Confederate government.

A faculty meeting of the Atlanta Medical College was held August 6, 1861. The secretary had started writing his minutes and had noted those present. He then began a new sentence, but for some reason it was never finished. It seemed as if some great catastrophe had suddenly overwhelmed the meeting. While local devastation did not come for nearly 3 years, the effects of the war were already at hand.[14]

The unfortunate Civil War soldier, whether he came from the North or from the South, arrived on the battle scene just when the killing power of weapons was being brought to a new peak of efficiency. And yet these were also the closing years of an era when the science of medicine was woefully, incredibly imperfect, so that he got the worst of it in two ways. When he fought, he was likely to be hurt pretty badly; when he stayed in camp, he lived under conditions that were likely to make him sick. In either situation, he had almost no chance of getting the kind of medical treatment which a generation or so later would become routine.[15]

The medical problems that confronted the doctors in uniform of the Confederate states Army and Navy were of considerable magnitude. With little or no training and experience in military medicine or surgery, and aside from the problem of preventive medicine, the medical staff was faced with the grave responsibility of caring for more than 3,000,000 cases of disease and wounds in an invaded and blockaded country. Joseph Jones, one of the most outstanding Confederate medical officers, estimated that the Confederate states mobilized more than 600,000 fighting men, that, on the average, each of these fell victim to disease and wounds approximately six times during the war. Jones figured that 200,000 Southern soldiers were either killed outright or died as a result of illness or wounds.[16]

Outside of Virginia, the greatest concentration of Confederate general hospitals was in Georgia. Here, after the Chattanooga-Chickamauga-Missionary Ridge campaign (June-November, 1863), 50 such institutions were in operation. Atlanta was an im-



DOWNTOWN PEACHTREE STREET in 1895: This view, from the roof of the old Aragon Hotel on the southeast corner of Peachtree and Ellis, offers a bird's-eye panorama of the buildings on the west side of the street. Left foreground, Richards or Abbott home; house with columns, the antebellum Leyden House, and, with cupola, the Governor's Mansion. Part of Peachtree Center now occupies part of the site beyond Cain Street.

(Photo courtesy of the Atlanta Historical Society.)

portant medical center. The gory Battle of Chickamauga sent hundreds of wounded soldiers to Atlanta, and the city's hospital and transportation facilities were badly overtaxed. Businessmen of the city were asked to close their offices at 4 P.M. in order to assist in caring for the wounded men arriving by train at the car shed. The citizens of Atlanta were asked to share their carriages and servants to assist in removing the injured to hospitals throughout the city. Homes, churches, schools, and private residences were pressed into service to provide room for the overflow of the hospitals. According to Surgeon Joseph P. Logan, medical officer in charge of the Atlanta hospitals, more than 10,000 soldiers were received into the hospitals of Atlanta in September alone, whereas the capacity of those institutions was not more than 1,800.[17]

As General Joe Johnston and the Confederate forces made successive strategic retreats and the Union forces moved on toward Atlanta, many people began to wonder if the city could withstand the assault. During the heat of all this speculation, the *Intelligencer,* to say the least, was maintaining a confident spirit. The following ad appeared on May 11, 1864:

LOOK AT THIS

"I have been in the practice of medicine for several years, and have made a discovery of a complete cure for cancers, old ulcers, polypus, fistulas, etc.

"I can be found at all times six miles northwest of Atlanta, on the Pace & Howell's Ferry Road. Address Concord P.O., Fulton County, Georgia.

Dr. F. C. Ford[18]

As the seige of Atlanta began in July of 1864, there was great alarm in the city for it was known that Sherman was approaching. An eyewitness of the times, historian Wallace P. Reed, recounts for posterity the following scene:

"In front of the present Kimball House, then the Atlanta Hotel, there was a park, the pride of the Atlantese, although not a little the worse for wear in those days. Near the hotel, during the progress of the battle, General Hood sat on his horse, surrounded by his staff, receiving messages every minute from the scene of action. A few score citizens lounged about the place, watching the iron face of the general, in the vain hope of reading his thoughts. Suddenly, the park was invaded by the hospital corps. Long tables were stretched out, and a crowd of professional men in uniform took charge of them and commenced to open instrument cases.

"They were surgeons. It was not long before ambulances and wagons began to roll into the park by the dozen, and the wounded were hastily taken out and placed upon the tables. After that, it was cut and slash, for the work had to be done in a hurry. The green grass took on a blood-red hue, and as the surgeon's saw crunched through the bones of the unfortunates,

hundreds of gory arms and legs were thrown into the baskets. This ghastly sight was too much for the lookers-on. They had seen one phase of the horrors of war, and they did not care to see more. One by one they disappeared, and soon the park was given over to the surgeons, the grim general meanwhile waiting the returns a few yards away.''

The shelling of Atlanta by Union forces began on July 20, 1864. During this time, thousands of wounded soldiers lay in the open for days. There was no morphine, no chloroform, and no antiseptics to be had. Doctors were tragically scarce, but the civilian aged and the women gave what aid they could to the wounded Confederates. When it was possible, the wounded were shunted off toward the south, on trains, in bullock carts, covered wagons, and open drays.[19]

The Confederate forces evacuated Atlanta on Sept. 1, 1864, leaving behind a dead city. By noon the next day, the entire length of Marietta Street was blue with Union forces. On September 7, on orders from General Sherman, General Hood directed that all civilians be evacuated from Atlanta. After partially burning Atlanta, Sherman began his now-famous March to the Sea on November 15, 1864. The Union Army had left a city in shambles, with its inhabitants scattered and morale at a low ebb.

Out of the Ashes

The fighting pioneer spirit of Atlanta, however, would not be denied, and the rebuilding began. By late 1864 and early 1865, Fulton County's government began to function again. Throughout the early months of 1865, a steady stream of exiled Atlantans returned to their devastated city.

One of the first problems to confront the city fathers of 1866, and the medical facilities of the city, was a smallpox epidemic. The Council ordered a temporary hospital built and placed $10,000 in the hands of the Relief Committee to meet the emergency.

About the same time Dr. Willis F. Westmoreland, on behalf of the Atlanta Medical College, offered to give free attention to the pauper sick. However, Council declined this offer because the ignorant poor people feared the college surgeons wanted their bodies for dissection. By August 10, when the epidemic had been brought under control, the Relief Committee reported total expenditures of $24,986.25, including maintenance of the smallpox hospital.[20]

It was also in August, 1866, on the 31st, that the Atlanta Medical College graduated its first post-war class, consisting of 28 fledgling doctors. The medical society had been meeting for several months, and the city's physicians were once again immersed in the practice of medicine.

A medical near-emergency occurred in Atlanta during August of 1888 when the city was flooded with a large number of refugees from Jacksonville, Florida, where a yellow fever epidemic raged. Beginning on August 14, every passenger train coming into Atlanta was carefully inspected by a physician, with one assigned to each of the railroads. Suspicious cases were promptly quarantined. Happily, however, no case of yellow fever was introduced into the area, nor did a single case develop among the thousands of refugees who passed through or who remained in Atlanta.[21] This all occurred prior to the work of Dr. Walter Reed, and whether instinct or fear prompted the exodus from Jacksonville, it was indeed the best course of action.

The period of time between the end of the Civil War and the turn of the century saw many changes take place in Atlanta and Fulton County. There was a tremendous surge of building, both commercial and residential. These years saw also the advent of many new businesses, new newspapers and journals, the electric streetcar, the Piedmont Exposition, cultural and educational advances and, of course, Coca Cola to mention a few. Medicine also forged ahead with improvements in education and medical knowledge, but the unprecedented medical advancements which would occur in medicine in the upcoming 20th Century would surely have been an impossible dream to the pioneer physicians of Atlanta and Fulton County.

References

1. Garrett FM. *Atlanta and Environs*. New York: Lewis Historical Publishing Co., Inc., 1954:150.
2. Ibid., I, p. 195.
3. Ibid., I, p. 217.
4. Knight LL. *History of Fulton County, Georgia*. Atlanta: A. H. Cawston, 1930:50.
5. Garrett, *op. cit.*, p. 306.
6. Georgia official and statistical register. Atlanta, Ga.: Dept. of Archives and History, 1967-68:970-975.
7. Garrett, *op. cit.*, p. 375.
8. Ibid., *op cit.*, 376.
9. Knight, *op. cit.*, p. 204.
10. Garrett, *op. cit.*, pp. 395-396.
11. Bulletin of the Fulton County Medical Society. 1955:29(4);7.
12. Martin TH. *Atlanta and Its Builders*. Century Memorial Publishing Co., 1902:173.
13. Garrett, *op. cit.*, p. 338.
14. Ibid., I, p. 509.
15. Catton B. (narrative) *The Civil War*. New York: American Heritage Publishing Co., Inc., 1960:359-360.
16. Cunningham HH. *Doctors in Gray*. The Confederate Medical Service, Baton Rouge: Louisiana State University Press, 1958:3.
17. Ibid., p. 125.
18. Garrett, *op. cit.*, p. 692.
19. Key W. *The Battle of Atlanta and the Georgia Campaign*. New York: Twayne Publishers, 1958:136.
20. Garrett, *op. cit.*, p. 705.
21. Ibid, ii, p. 164.



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

Though we met with some setbacks, these were outweighed and overshadowed by several important accomplishments that assured continuing quality patient care for the people in Georgia.

1980 Medical Legislation Wrap-up

JAMES A. KAUFMANN, M.D., and RUSTY KIDD, *Atlanta**

THE 1980 Georgia General Assembly saw an influx of more health-related legislation than ever before. During this 40-day session, there were some 163 health-related bills introduced into the Georgia General Assembly. The Medical Association of Georgia (MAG) submitted testimony before some 16 different legislative committees and lobbied strongly on some 46 of the 163 bills. Although this was the most frustrating year we can remember in the legislative arena, due primarily to the great number of complex medical issues voted on in the 40-day period, our legislative successes on issues of concern to the MAG outweighed and over-shadowed our losses. The following is a list of a few of those bills introduced and debated on in the 1980 legislature:

Medicaid Appropriations

Among the highly controversial appropriations bill, the MAG was successful in adding approximately $4,000,000 into the benefits payment division of the Department of Medical Assistance for reimbursement of physicians' medicaid fees. In accordance with this additional money, the language was specified in the Department of Medical Assistance to equate physicians' fees throughout Georgia. In essence, this would bring Georgia into a one area designation of medicaid reimbursement.

Canadian Medical Licenses

House Bill 599 was the first bill to become law this year which permits graduates of approved Canadian medical schools to apply for and receive a license to practice medicine in Georgia.

Definition of a Physician

House Bill 652 was withdrawn late in the session when the Attorney General and the Insurance Commissioner indicated that current laws and regulations specify only medical doctors and osteopaths can consider themselves physicians.

Fifth Pathway Program

House Bill 885, which would have mandated that Georgia have a Fifth Pathway Program, did not pass. MAG, the State Board of Medical Examiners, and the Medical College of Georgia have opposed a mandatory Fifth Pathway Program.

Experimental Research — Marijuana

House Bill 1077, which passed, permits Georgia physicians and patients who qualify under the Composite State Board of Medical Examiners in accord with rules by the FDA, to use marijuana in the experimental research for cancer patients and glaucoma patients.

Medicaid Filing of Claims

House Bill 1099 passed and extends up to 6 months the time of filing a claim for medicaid by physicians and hospitals.

Eye Banks

House Bill 1186, which passed, permits the removal of eye tissue from decedents for the purpose of cornea transplants, etc.

Medical Examiner — DeKalb County

House Bill 1234 passed and permits DeKalb County to abolish the office of Coroner and replace said person with a fulltime medical examiner.

* Dr. Kaufmann is Chairman of MAG's Committee on Legislation. His address is 950 W. Peachtree St., NW, Atlanta, GA 30309. Mr. Kidd is Director of Legislative Activities for the MAG. His address is 938 Peachtree St., NE, Atlanta, GA 30309.

Emergency Medical and Cardiac Technicians — Ambulance Service

House Bill 1376, which passed, permits the Composite State Board of Medical Examiners to subpoena records of ambulance services regarding the use of emergency medical and cardiac technicians. HB 1376 also requires that all ambulance services in counties with a 12,000 population or more have a medical advisor to each and every ambulance service.

Podiatry

House Bill 1403, which would have required hospitals to consider applicants for staff privileges from podiatrists and others, did not pass. House Bill 1404, which changed the limitations of advertisement for podiatrists, did not pass. Neither did House Bill 1405, which changed the definition of podiatric practice to treating ailments of the human foot and leg distal to the knee.

Chiropractic

House Bill 228, which passed, permits chiropractors to be reimbursed for services within their scope of practice under health and accident insurance policies. The language of House Bill 228 permits insurance companies to specifically exclude chiropractic services if they so desire. This means that an insurance company can exclude chiropractic services.

Mental Disorder Insurance

House Bill 83, which did not pass, would have required insurance companies to offer at parity mental illness benefits. These benefits would be strictly up to the purchaser to buy and pay accordingly. HB 83 would not have mandated the inclusion of said coverage.

Sterilization Procedures

House Bill 122 did not pass. It would have changed the existing law to require two physicians to consult prior to a sterilization procedure and a waiting time of 90 days.

Catastrophic Health Insurance

House Bill 139, which passed the House of Representatives but did not pass the Senate, would have established a mechanism by which insurance companies would offer and include catastrophic benefits in health and accident insurance policies.

Optometry

Senate Bill 44 and House Bill 394, which permitted optometrists to use diagnostic agents, did not pass. SB 31, however, which dealt only with adding a consumer to the Board of Optometry, was amended by substitute on the floor of the House by Representative Phil Johnson of Covington and Representative Crawford Ware of Hogansville to include, in essence, the substance matter of Senate Bill 44 permitting optometrists to use diagnostic agents. For the past 5 years, the MAG and the Georgia Society of Ophthalmologists had been successful in defeating this legislation in their respective committees, but were unable to defeat this subversive tactic during the 1980 session. SB 31, as amended, passed the Senate by only three votes.

Confidential Psychiatrist-Patient Privilege

Senate Bill 115, which would have breached the confidentiality between psychiatrist and patient, was defeated.

In-Patient — Out-Patient Insurance

Senate Bill 217, which passed, sets up a mechanism by which the insurance commissioner's office, in consultation with the Department of Human Resources and the Georgia Medical Care Foundation, will promulgate rules and regulations to insurance companies of Georgia requiring that certain procedures that are currently reimbursable only on an in-patient basis will be reimbursed on an out-patient basis.



There is no greater happiness in life than that of surmounting difficulties, and nothing will conduce more than this to improve your intellectual faculties, or to make you satisfied with the situation which you attained in life, whatever it may be.

Sir Benjamin Collins Brodie
Clinical Lectures on Surgery



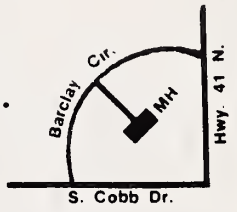
Morrill House

Elegant Dining, Country Simplicity

Reservations accepted until 9

404/422-2267 1266 Barclay Circle S.E.

Marietta, Georgia



THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



THE ULTIMATE DRIVING MACHINE.

BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730

The author discusses the relationship between lithium carbonate therapy and potassium deficiency and the possible role they play in heat-associated injuries.

Heat Injury: A Possible Association With Lithium Carbonate Therapy

DAVID LOWANCE, M.D., *Atlanta**

HEAT-ASSOCIATED INJURY is being seen with increasing frequency as jogging becomes more prevalent and as awareness of heat injury rises. Few disorders transpose apparently healthy individuals to a state of critical illness as rapidly as heat stroke. Physicians should be aware of disorders associated with heat injury and should counsel their patients regarding the advisability of strenuous exercise in warm environments.

There are differences between those individuals who experience heat stroke and those who do not, given that the amount of exercise is equal for both groups. Factors that have been clinically implicated as predisposing persons to the development of heat stroke include state of prior physical conditioning, pre-existing cardiovascular disease, presence of a debilitating disease, diabetes mellitus, impairment of sweat production due to pharmacologic agents or sweat gland disease, primary muscle disease, and, more recently, potassium deficiency.[1]

The following case is presented to point up the possible role of potassium deficiency in the development of heat-associated injuries and to alert physicians to yet another drug, lithium carbonate, that might lead to potassium deficiency under certain conditions.

Case Report

A 38-year-old white man collapsed with convulsions three quarters of the way through a 6-mile road race in Atlanta in the spring of 1979. Prior training consisted of running 15-25 miles a week in the same environment. The patient's race-timed minute miles, however, were 1 to 2 minutes faster during the race. Emergency ice tub cooling was done in the ambulance en route to a nearby hospital where initial rectal temperatures were recorded at 106.7°F. Pulse rate was 190/minute, blood pressure was 100/70. Therapy was continued with cooling, intravenous dextrose, and saline. Within the next 48 hours, urine output diminished, and Heparin therapy was initiated for prolongation of PTT, prothrombin time, and falling platelets. Serum creatinine and BUN rose rapidly to 6.9 mg% and 60 mg%, respectively. The patient was transferred to Piedmont Hospital for management of his renal failure. The highest serum potassium level at the referring hospital was recorded at 4.8 meq/L at a time when his total carbon dioxide was 7 and anion gap 31. The remaining potassium determinations were less than 4.0 meq/L.

Physical examination on admission to Piedmont revealed an acutely ill man with a blood pressure of 130/90, pulse 76, temperature 99°F. rectally, and respiration 16. Admission laboratory data included: Hgb 14.3, Hct 40, WBC 10,200, platelets 66,000, protime 18.5/12.1, PTT 47/28, fibrin split products greater than 40 meq/ml, CPK 33, 700 iu, uric acid 20.0, creatinine 7.6, BUN 24, potassium 4.8, carbon dioxide 7, SGOT 3560, LDH 2150, calcium 7.6, phosphorus 5.0, and albumin, 3.5.

During the ensuing 5 days, the patient received large amounts of intravenous fluids and Heparin anticoagulation. Urine volumes were maintained in excess of 2000 cc/24 hours with a combination of fluids and furosemides. His creatinine continued to rise and by the third hospital day was 12.0 mg%, with a BUN of 82 mg%. Serum potassium remained less than 4.0 during this additional 72-hour period despite daily administration of greater than 200 meq.

* Dr. Lowance practices internal medicine and nephrology at Piedmont Hospital. His address is 35 Collier Rd., NW, Suite 610, Atlanta, GA 30309.

of potassium chloride intravenously. A 4-hour creatinine clearance was 10 cc/min on the fourth hospital day.

The patient's course improved dramatically during his second 4 days of hospitalization, and he was discharged 11 days after his initial collapse with serum creatinines between 3-4 mg% and clotting parameters normal. One month later the patient's serum creatinine was less than 1.0 mg%, and all other laboratory studies were normal.

At the time of his hospitalization, the patient's wife informed us he had been receiving lithium carbonate 300 mg twice daily for management of manic-depression.

Discussion

The present case illustrates the dramatic nature of heat stroke, the rapidity with which it develops, the severity of the acute illness, and the rapidity with which it can clear if complications can be managed. In addition, potassium deficiency as an associated cause of rhabdomyolysis is suggested.

That potassium deficiency may play a role in muscle injury appears to be well established.[2,3] Although balance studies are not available in the present case, pre-existing potassium deficiency is suggested by the failure of the serum potassium to rise above 4.9 meq/L in the presence of stressful muscle exercise, acidosis, and acute renal failure.

If potassium deficiency is present, vasodilation is impaired and rhabdomyolysis is possible.

During the patient's first 5 days of treatment, over 800 meq of potassium chloride were administered intravenously. Even assuming his creatinine clearance was 10 cc/min (as measured on the fourth hospital day when recovery was eminent), it appears unlikely that enough renal function was present to allow for excretion of more than a small fraction of this administered load.[4] This suggests that he might have retained large quantities of potassium during this period of observation without developing hyperkalemia. Such positive potassium balance is consistent with the hypothesis that a pre-existing potassium deficiency existed at the time of his initial injury.

Factors known to predispose an individual to potassium deficiency include diuretics, diarrhea, malabsorption, villous adenoma of the rectum, vomiting, laxative abuse, mineralocorticoid excess, renal tubular acidosis, thyrotoxicosis, therapy with Amphotericin B, Carbenicillin, and PAS.[3]

Results of Other Investigations

In the last 20 years, Schwartz and co-workers[4] have emphasized the role non-reabsorbable anions have in the development of acid-base disorders and potassium deficient states. The delivery of non-reabsorbable anions to distal tubular sites in the presence of sodium avid states enhances the reabsorption of sodium (if available with the anion) in exchange for hydrogen and/or potassium. Sodium avidity generally exists as a result of extracellular salt depletion or as a result of mineralocorticoid excess. The latter cause is frequently associated with ECF volume expansion and massive delivery of sodium to distal exchange sites.

Physicians should counsel their patients regarding the risks and precautions associated with strenuous exercise in warm environments.

Knochel and his associates[6] have investigated the renin-aldosterone axis in individuals undergoing physical training in warm climates. They have devised a hypothesis suggesting that periodic rises in aldosterone excretion may promote potassium excretion during physical conditioning in warm environments. Physical work in heat promotes sweating, results in decreased ECF volume with subsequent renin release and aldosterone production. Following exercise, subjects often injest large quantities of salt and water thus re-expanding ECF volume. Distal tubular sodium delivery is enhanced as ECF volume rises. Since aldosterone activity often lasts up to 8 hours, a distal tubular sodium avid state exists at a time when distal sodium delivery is high and available for potassium exchange. Intermittent potassium loss, if not replaced, may create a large negative potassium balance. Normally, during exercise, intracellular potassium is released to the interstitial space and acts as a potent vasodilator, assisting in the delivery of oxygen required by the exercised muscle. If potassium deficiency is present, vasodilation is impaired and rhabdomyolysis is possible.

In our patient, a relatively nonreabsorbable anion, carbonate, was being injested during a period of physical conditioning in a warm climate. The potential for developing massive potassium deficiency was great. Indeed, in one published study,[7] potassium deficiencies greater than 800 meq have been induced in normal men by the administration of sodium bicarbonate and aldosterone. Such degrees of severe potassium deficiencies may be associated with rhabdomyolysis even in the absence of strenuous exercise.[8]

Summary

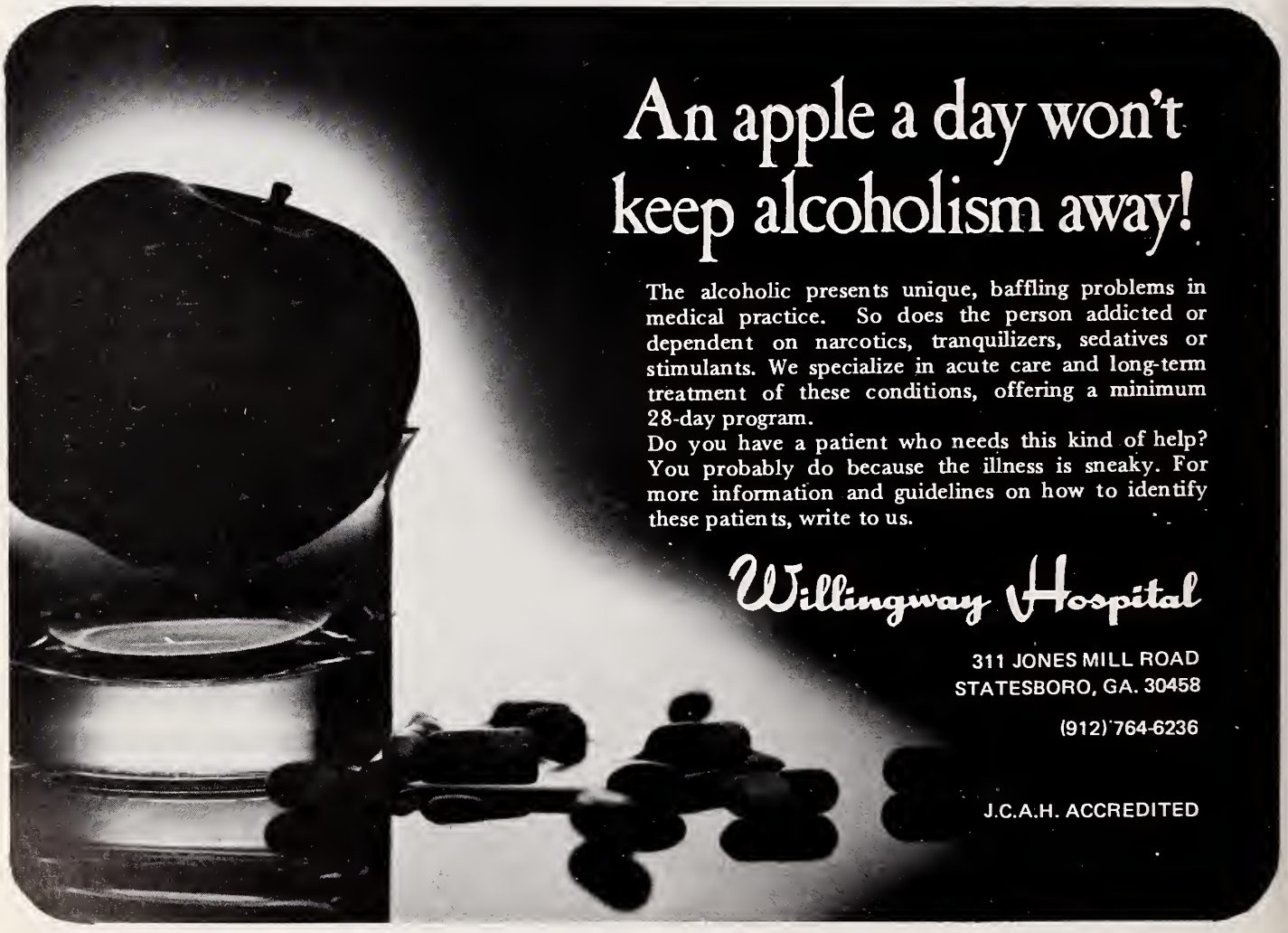
Heat stroke developed in a 38-year-old man while running a road race in a hot climate. Prior physical

conditioning had taken place, and no other underlying metabolic disease or disorder of sweat gland metabolism was present. The patient appeared to have a significant potassium deficiency at the outset of the race as suggested by a normal potassium despite large amounts of potassium replacement, the presence of acidosis, muscle injury, and renal failure. It is suggested that his potassium deficient state developed as a result of the interaction between endogenous aldosterone production at a time when a relatively non-reabsorbable anion was being injested as carbonate as a lithium salt.

Patients using this drug and prone to situations increasing aldosterone production should be monitored for the development of potassium deficiency. Appropriate potassium replacement should occur before engaging in strenuous exercise.

References

1. Knochel JP. Environmental heat illness. Arch Int Med 1974;133:841-864.
2. Knochel JP. On the mechanism of rhabdomyolysis — potassium depletion. J Clin Invest 1972;51:1750-1758.
3. Knochel JP. Rhabdomyolysis and the effect of potassium deficiency on muscle structure and function. Cardiovas Med 1978;3:247-261.
4. Leaf A, Cotran R. *Renal Pathophysiology*. New York: Oxford University Press. 1976; p. 115.
5. Schwartz WB, Cohen JJ. Nature of the renal response to chronic disorders of acid-base equilibrium. Am J Med 1978;64:417-427.
6. Knochel JP: Exertional rhabdomyolysis. N Engl J Med 1972;287:927-929.
7. Kassirer JP, Lowance DC, Schwartz WB. Aldosterone induced metabolic alkalosis in man. Proceedings, Amer Soc Nephr 1971:36.
8. Lowance DC: Unpublished observations.



PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

The Complete Communication Company..

OFFICE COMMUNICATIONS INCORPORATED*

The Portables



NORELCO NT-1



NORELCO 185

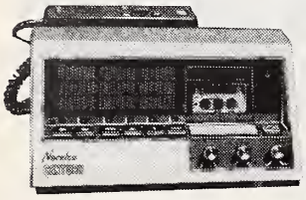


DORO 706



SAN 1500

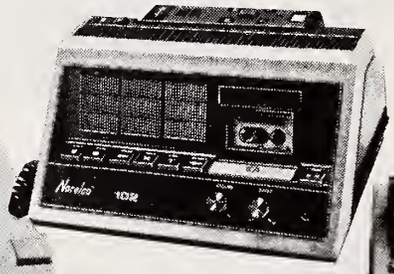
Desk Top Dictation/Transcription Systems



NORELCO CENTURY



DORO 707



NORELCO 102

DORO 705

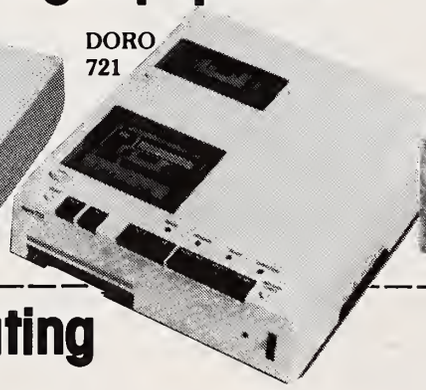


NORELCO 186

Phone Answering Equipment



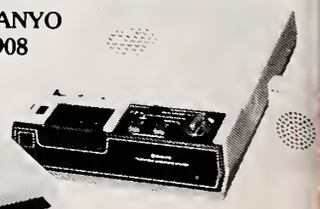
SANYO 139



DORO 721



DORO 320



SANYO 9908

Telephone Dictating



NORELCO 260



DORO 732

*One Stop Communications Sales and Service...

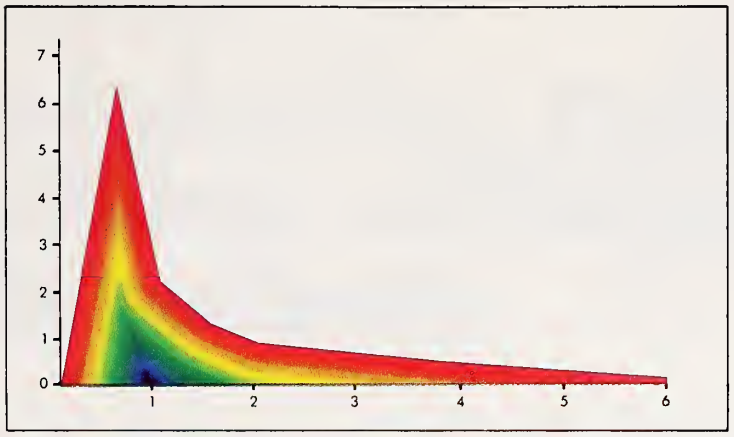
OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry: Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service department throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED

6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741

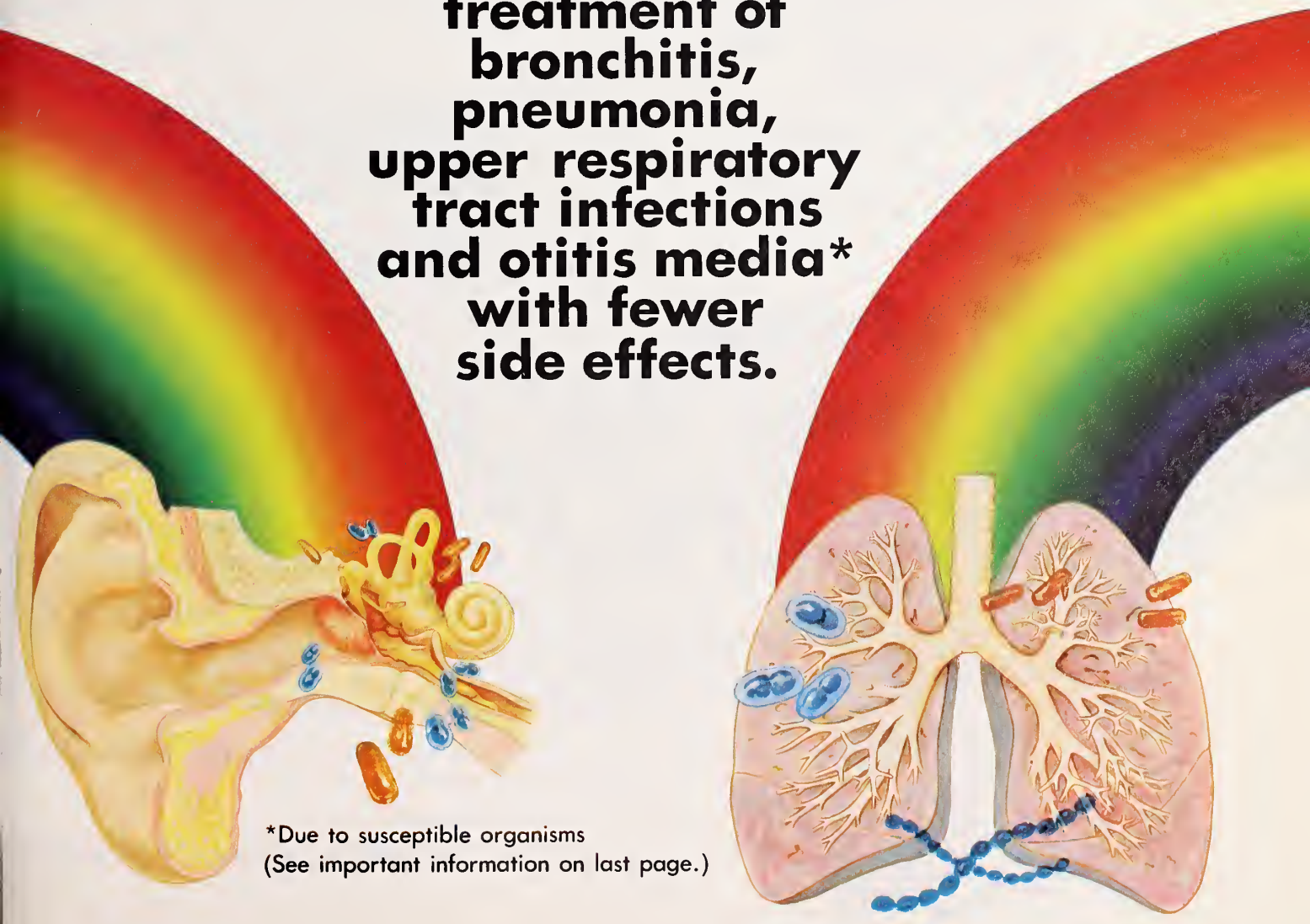
more than just spectrum



New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of bronchitis, pneumonia, upper respiratory tract infections and otitis media* with fewer side effects.



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN®
(cyclacillin) Tablets/ Suspension

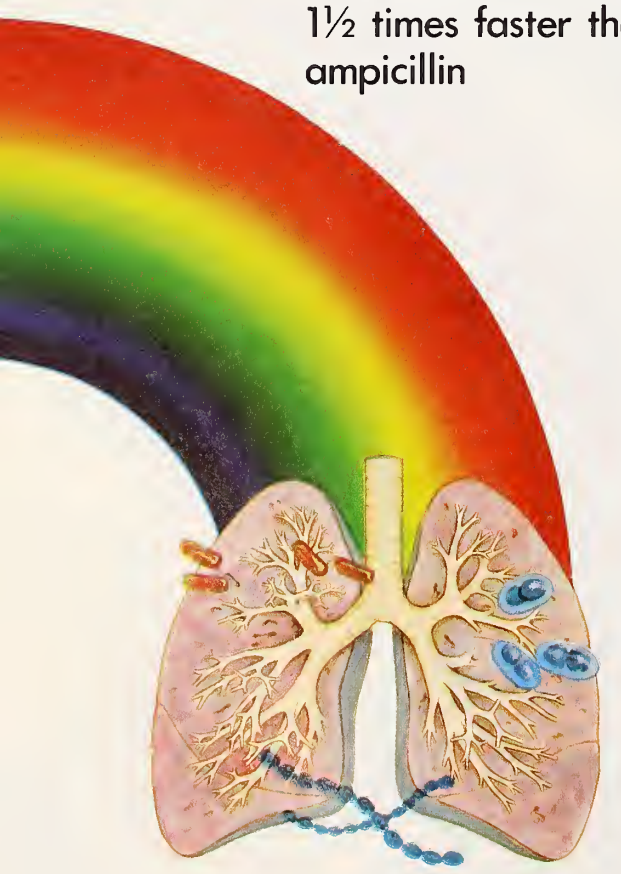
efficacy with fewer side
ampicillin confirmed in
studies of 2,581

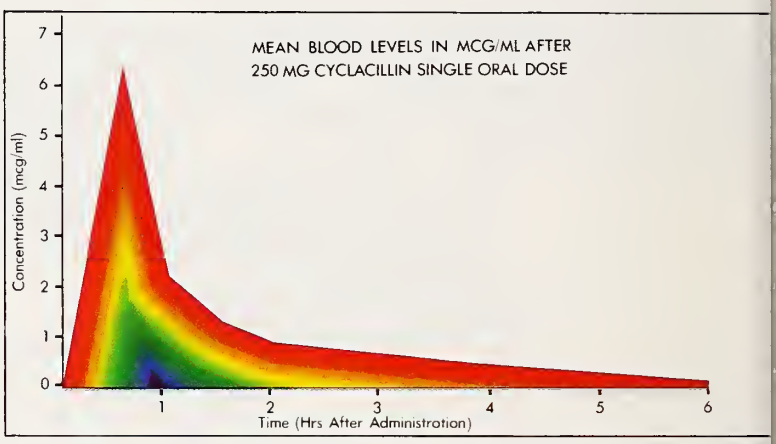
Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin





High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100 / 95	73
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100 / 86	44
	% Clinical Response % Bacterial Eradication	

more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

Copyright © 1979, Wyeth Laboratories. All rights reserved.

effects than double-blind patients*

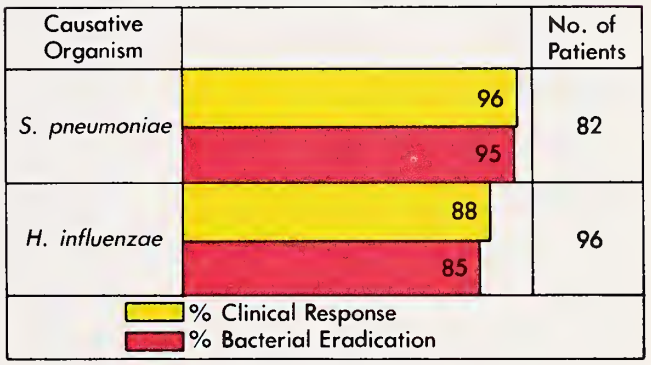


Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant ($P < 0.001$)	

more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†



CYCLAPEN® (cyclacillin)
Effective for bronchitis, pneumonia, and upper respiratory tract infections†

- Excellent clinical results in bronchitis, pneumonia and upper respiratory tract infections
- Significantly lower incidence of diarrhea and skin rash

1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.

more than just spectrum

CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Wyeth Laboratories
Philadelphia, Pa. 19101

(See important information on next page)

New from Wyeth Laboratories

CYCLAPEN®
(cyclacillin) Tablets/ Suspension



more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY. Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended.

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥ 10 mg %, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa. 19101

The author describes and discusses a far-reaching new goal of the World Health Organization in which an idea whose time is coming takes some substantive shape.

"Health for All by the Year 2000": Can We Afford Such a Future?

JOHN H. BRYANT, M.D., *Washington, D.C.**

J. FORESTER, the eminent computer engineer and futurist from the Massachusetts Institute of Technology once said that our purpose in analyzing the possibilities that lie ahead is not to predict the future as though it unfolds through some series of events that we watch passively, if knowledgeably. "Our purpose is to create the future," Forester said. "To understand what we want, and then to shape events that will bring that future about." We should not smile too quickly at Forester's interesting, if audacious, intent. He takes a position of fundamental importance, namely, that we can shape the future that lies before us. I join Forester, at least in hope, if not in his certainty.

J. Forester said, "Our purpose is to create the future, that is, to understand what we want, and then to shape events that will bring that future about."

But if this exercise of creating the future is not to be trivial, it must deal with the serious problems of our world and of mankind. Among the many serious global problems that could be considered, I choose to deal with problems of deprivation and social justice on a world scale.

We might wish for much greater equity or justice in the distribution of social and material goods, but our understanding of what is real and practical steers us away from utopias and unreality. Nonetheless, one question sticks and stubbornly calls for an answer: Is there a minimum or a flow of basic human needs that must be met, and, therefore, must be afforded as an essential part of the future?

If that question is answered affirmatively, it means that the game of creating alternative futures is not one of open choice. At least with respect to basic human needs, the game is partly closed. There is a minimum acceptable level of services or opportunities for meeting those needs, and, quite simply, they must be afforded. If that is the case, and to the extent that is the case, the question: "Can we afford the future?" is taken away. The future defines itself, and we must afford it.

"Health for All by the Year 2000"

Is this notion of creating the future according to certain moral imperatives only a game? I don't think so, and I intend to show that by discussing some recent developments in the international health field.

The World Health Organization (WHO) recently announced a major new goal: to achieve "Health for All by the Year 2000." Where did this idea or hope come from? Is it just another flashy slogan? Or will it draw serious commitments from the community of nations?

The idea of "Health for All" emerged during the debate on what is known as the New International Economic Order, the movement on the part of the less-developed countries to achieve a fairer share of the world's economy, particularly in relation to international trade. Dr. Halfdan Mahler, Director-General of WHO, as an expression of interest and concern for the efforts of the poorer nations to accelerate their rates of development, proposed that the member nations of WHO adopt this goal of "Health for All by the Year 2000."

* Dr. Bryant is Deputy Assistant Secretary for International Health, Department of Health, Education, and Welfare, Rockville, Maryland 20857. This paper was originally presented at the 14th Annual Cobb County Symposium at Kennesaw College in Marietta, Ga, in April 1979.

This idea could have been just another of the many interesting ideas to come and go as our years roll by, but something special happened with this idea, rising perhaps out of the convergence of three factors:

1. The magnitude of the need of the poor of our world:
 —800 million people in absolute poverty;
 —⅓ of all deaths occurring in children under the age of five years;
 —70-95% of the populations of poorer countries without access to health services.
2. The moment in history:
 —the disappointments of many newly independent countries that their immediate hopes were not being realized;
 —the importance of having long-term goals;
 —the year 2000 as a goal, time enough to allow for planning and striving, near enough to be realized within a lifetime.
3. The credibility of the man who proposed the idea:
 —Halfdan Mahler, son of a Danish parish minister, who spent many years in developing countries;
 —technically competent, socially committed, politically astute;
 —with the confidence of both less-developed and more-developed countries.

Whatever the reasons, the idea caught on with both the more-developed and less-developed countries. A world conference on primary health care was held in Alma Ata in the Soviet Union in mid-1978. A total of 142 nations and many voluntary organizations affirmed the concepts of "Health for All by the Year 2000" and issued the Declaration of Alma Ata.[1]

A key statement in the Declaration reads as follows:

> "A main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead socially and economically productive lives. Primary health care is the key to attaining this target as a part of development in the spirit of social justice."

The Declaration goes on to define primary health care, which it states should include:

> "1. education concerning prevailing health problems and the methods of preventing and controlling them;
> 2. promotion of food supply and proper nutrition;
> 3. an adequate supply of safe water and basic sanitation;
> 4. maternal and child health, including family planning;
> 5. immunizations against the major infectious diseases;
> 6. prevention and control of locally endemic diseases;
> 7. appropriate treatment of common diseases and injuries; and
> 8. provision of essential drugs."

Some Obvious Obstacles

The Declaration and recommendations of Alma Ata were brought to the Executive Board of WHO which met in January, 1979, in Geneva. In the setting of that body, with members from 30 countries, the United States had to take a position on the concept of "Health for All by the Year 2000." What could have been only a game of the future became a matter of governmental policy. Before describing our official reaction and that of others, I will briefly describe some of the major problems that need to be surmounted if "Health for All" is to become a reality.

First, the pattern of disease. Examples of the major health problems are: infectious diseases, malnutrition, problems associated with population growth, and complications of pregnancy and childbirth. A vivid example that stands out in the midst of these problems is that of low birthweight babies. Twenty-two million low birthweight babies are born in the world each year. One million of these are born in more-developed countries, and for the most part they are small because they are premature. Twenty-one million babies are born at low birthweight in the less-developed world, and for the most part they are born at term but are small because they are undernourished. They have a 20 times greater likelihood of dying in the first year of life than a baby born at normal birthweight. Many of those who survive will become undernourished and undersized mothers who then give birth to low birthweight babies.

Reflect on the kinds of personal and community technologic changes that are necessary if such problems are to be supplanted with healthy mothers who give birth to healthy babies who become mothers of healthy babies.

A second set of obstacles has to do with resources and institutional capabilities.[2] Money for health in Africa, Asia, and parts of Latin America is so limited as to be barely comprehensible by those of us who live in the more affluent world. Governmental money available for health services in most of Africa and Asia is less than $1 or $2 per person per year. India is providing health services for its 500 million rural people on 3 to 5 rupees per year — or 45-60¢.

Health expenditures in the United States, by contrast, amount to about $800.00 per person per year.

Physicians are also scarce, national ratios ranging from 1 for every 3000-4000 people to 1 for every 30,000-40,000 people. But even these ratios understate the problem. Physicians the world over cluster in the major cities, where the concentrations approach those of our own cities, while in the rural areas, where the majority of the population live, the ratio is 1 to 25,000, 1 to 100,000, and, on occasion, 1 to 500,000.

The reality is that in most of the less-developed world, people receive health services under circumstances in which there is little more than a dollar per person per year and one physician for every 25,000 to 50,000 people.

Facilities are also limited in numbers, distribution and equipment, though often the more sophisticated facilities, such as university hospitals, become part of the problem, because they absorb disproportionate amounts of money and professional personnel.

Between 70% and 95% of the populations of poorer countries are without access to health services.

There are also limited capabilities in planning, managing, research, and education. That picture is spotty, however, because some of the most brilliant people in those fields are in the less-developed world. The problem is that their numbers are so limited, given the magnitude of the problems.

The third major obstacle to achieving "Health for All" is the limited social and political commitment of nations around the world. Health is usually given low priority, and ministers of health have limited clout at the budgetary bargaining table. Power is in the hands of the powerful, and the poor are powerless. The changes that are necessary to direct more resources toward the poor are largely political decisions. They involve political power and political dangers. WHO's Dr. Mahler is convinced that political will is the most important ingredient for achieving "Health for All."

In the face of these obstacles, which form a somewhat dismal picture, it is not surprising that Mahler's goal of "Health for All" has met with mixed reactions. The skepticism ranges from those who think the goal is plainly silly to those who believe that it is sloganeering of the worst kind, because it cruelly raises expectations and distracts us from getting on with the practical steps that can be taken at this time.

Some Positive Advocacy

But the goal also has its advocates, those who believe that it is a crystallizing point for interest and commitment to the needs of the poor, and some have grasped the idea with a religious fervor.

At Alma Ata, there was an interesting difference between participants from the less-developed and more-developed countries, a difference that went beyond skepticism or advocacy. Those from the more-developed countries appeared to focus mainly on what is meant by *health* in "Health for All." They asked technical questions about health and how it is to be provided. Those from the less-developed parts of the world were more interested in the other side of the expression — the *all,* in "Health for All"; the idea of social equity. Let us be careful, they said, not to allow quality of care to be used as an excuse for not reaching everybody with some health care, whatever its quality. That is, equity should have priority over quality.

There was drama at the meeting of the WHO Executive Board in January, 1979, because this was the first time that WHO dealt officially with the question. The meeting of Alma Ata was organized by WHO and UNICEF, but did not represent a formal meeting of a governing body of those organizations. Thirty member nations were represented at the circular table of the Executive Board, and one by one they spoke. China, India — those two countries alone will contain half of the world's population by the turn of the century — Pakistan, the United Kingdom, France, Burma, Cuba, Burundi, Libya, Botswana, the Soviet Union, Mexico, and on around the table. One by one they endorsed the concept of "Health for All by the Year 2000." So did the United States. There was no dissent. The comments were cautious, to be sure. The discussions turned on the immense problems and the deep needs of each country. Each person described the needs of his or her country in its own social, political, and cultural uniqueness. Despite the wide-spread recognition of the practical difficulties of achieving the goal, there was in the room a sense that an historic opportunity was at hand, that we must seize it, and we must move with it.

A total of 142 nations and many volunteer organizations affirmed the concepts of "Health for All by the Year 2000."

What is the basis for such positive statements? Those around that table, men and women from six continents, were neither naive dreamers nor politicians making statements for effect. What do they see in their countries and in the world that leads them to insist that the WHO goal is worth supporting? There is evidence at hand that gives us hope, but before examining that evidence, let us be clearer about what is meant by "Health for All."

More Definitive Criteria

"Health for All" cannot mean that all will be healthy. There is no physiological, philosophical, or theological reason for expecting that. It has to mean that there will be access of all people to health improving services. Both sides of that statement are essential if we are to be consistent with the Declaration of Alma Ata. First, all just have access to health services — equity and justice require that. Second, the services must improve poor health or maintain good health. If health services are not effective, then the ideal of equity of access becomes a mockery of meeting human needs. In these terms, will it be possible by the year 2000 to reach all or nearly all with health improving services on resources that are available, say, $1 to $3 per person per year, allowing for some growth before the year 2000?

For partial answers, let us look at the record. In Jamkhed, Maharashtra State, India, one of the poorest states, a husband and wife team, Maybel and Raj Arole, Indian Christian physicians who work as missionaries to the rural poor of India, have been working in an impoverished rural agricultural area promoting health services as an integral part of community development. In the first 4 years of their program, in the early 1970s, they were able to reach virtually all of a population of 40,000 rural people with health services at an annual expenditure of 5 rupees, or 60¢ per person. Infant mortality was more than cut in half, and the birth rate was reduced by more than a third.[3]

"Health for All" does not mean that all will be healthy — it intends that there will be access of all people to health improving services.

Other examples can be given in Asia, Africa, and Latin America. Most of these examples occur under special circumstances: they are limited in scope and involve inspired leadership. The programs are intimately related to the social and political system of the area, and, importantly, the programs draw on community resources and build on the interest, commitment, and the creativity of communities.

The call on community resources deserves special emphasis. In all countries, rich and poor, resources are limited relative to need, but the discrepancies are particularly vast in the poorer countries. There is little possibility of achieving total coverage of populations using resources emanating only from centrally-planned, centrally-financed health services. Community resources — buildings, money, power, creativity, community support systems — are highly important ingredients to achieving "Health for All."

Any discussion that deals with reaching large populations with health services on limited resources must include mention of the People's Republic of China, the Soviet Union, and Cuba. There, too, have been special circumstances, inspired leadership, and an interaction of health and the social and political structures. Indeed, one recognizes that social and political decisions are often more important than technical decisions.

The Role of the United States in "Health for All"

To which countries does the goal of "Health for All by the Year 2000" apply? We have taken the position, officially, that the challenge is not alone for the less-developed countries but for the more-developed countries as well. Two reasons underlie that position. One is that we feel the movement is doomed if it is seen as applying to poor countries only, if it is viewed as an effort in which some countries are struggling to achieve "Health for All" and others are watching from the sidelines. "Health for All" includes all countries and all people. Second, the United States has a developing sector of its own. Substantial numbers of people in rural and urban areas have inadequate access to health care, and often the care they receive does not answer the problems they have.

One of the most tragic, 10-mile drives in the United States is from Riverdale, an affluent suburb of New York City, through northern Manhattan into central Harlem. In the space of those 10 miles, the infant mortality increases five-fold, from a level comparable to that in Sweden, in affluent Riverdale, to a level found in some of the Asian and Latin American countries in central Harlem.

The more-developed countries also suffer from the problems of over-development, what Marc LeLonde called "the dark side of development": profligate use of energy, contamination of the environment, adolescent health problems in an affluent society, the difficulties of providing for the needs of the elderly in an aging society.

Perhaps the most important aspect of "Health for All" is that it is not our show — it is the world's show.

For these reasons, "Health for All by the Year 2000" has a special meaning for the United States. We have formed a Task Force within the U.S. Government on "Health for All by the Year 2000 — U.S.A." That task force will define the meaning of "Health for All" in U.S. terms, examine current relevant policies and programs, and recommend alternative future policies. Simultaneously, we have formed a study committee in the Institute of Medi-

cine of the National Academy of Sciences to bring our best health scientists to examine the implications of "Health for All by the Year 2000 — U.S.A." for domestic health policy of the United States. The work of these two groups will be closely coordinated in formulating future domestic health policies for the United States.

So, at the Executive Board and other fora of WHO, we have taken positions strongly supportive of the goal of "Health for All," but we have done it with some humility, and that is the subject I wish to turn to at this time. I have made the point that it is possible to achieve "Health for All" under special circumstances. The task ahead is to extend those possibilities to a wider variety of circumstances and to the very large populations of people.

The role of the United States vis-à-vis other nations in pursuing the goal of "Health for All" needs to be seen in the context of some of its current domestic problems, as well as its recent history in dealing with similar issues. Hazel Henderson spoke of the United States being headed for a necessary downturn from its energy-intensive, technology-intensive, cooperative-centered way of life. The current modes simply cannot be sustained.[4] What does that say for the paths that the less-developed countries are taking in their intense interest to develop economically? Are they following development paths into the same unsupportable and unaffordable future that we are careening toward as one of the most developed nations?

Is "Health for All" simply a dream? Consider: just as thinking about ultimate truths leads us to discover worldly truths, so dreams give rise to important and practical ideas.

James Laney described the period of social expansion in the United States in the 1950s when the mood was to make the good life available for all. John Kennedy caught that mood saying, "We must be ready to go anywhere, carry any burden, pay any price." But the rosy dreams of the 50s collapsed into the social disillusionment of the 60s and the self-serving, inward-turning of the 70s.[5] We can now ask, "What will be the mood and the mode of the 80s and 90s?"

Let me dare to suggest that "Health for All by the Year 2000," in its brief life and evolution to date, provides some hints about where we will be or can be in the 80s.

The social disillusionment of the 60s and the self-interest of the 70s may give way to new kinds of commitment to relate to the wider society, in this particular instance, the global society of the 80s. Not with the "go anywhere, carry any burden, pay any price" of John Kennedy's 50s, because we understand better now that our resources are *not* the most crucial resources, that our answers are *not* the universal answers, and that *we* have problems of development, too. Our commitment in the 80s will have some newness to it. It will still be based on human concerns for the needs of man, but we will understand that those concerns are for ourselves as well. We will still want the good life to be available for all, but we are less sure what the good life is, where to find it, and how to support it. We have to ask others, even the poorest of others, to join with us in searching for it. Our resources will still be important, but we will understand better that the crucial resources for the problems of the poor countries will be their resources. Perhaps the most important aspect of "Health for All by the Year 2000" is that it is not our show. It is their show, the world's show, and we have the opportunity of being a participant, an important participant, but a humble participant. Perhaps that is the key to our social commitment of the 80s. It will be a commitment shared with others who need help as we all need help.

"Health for All" — Dream or Reality?

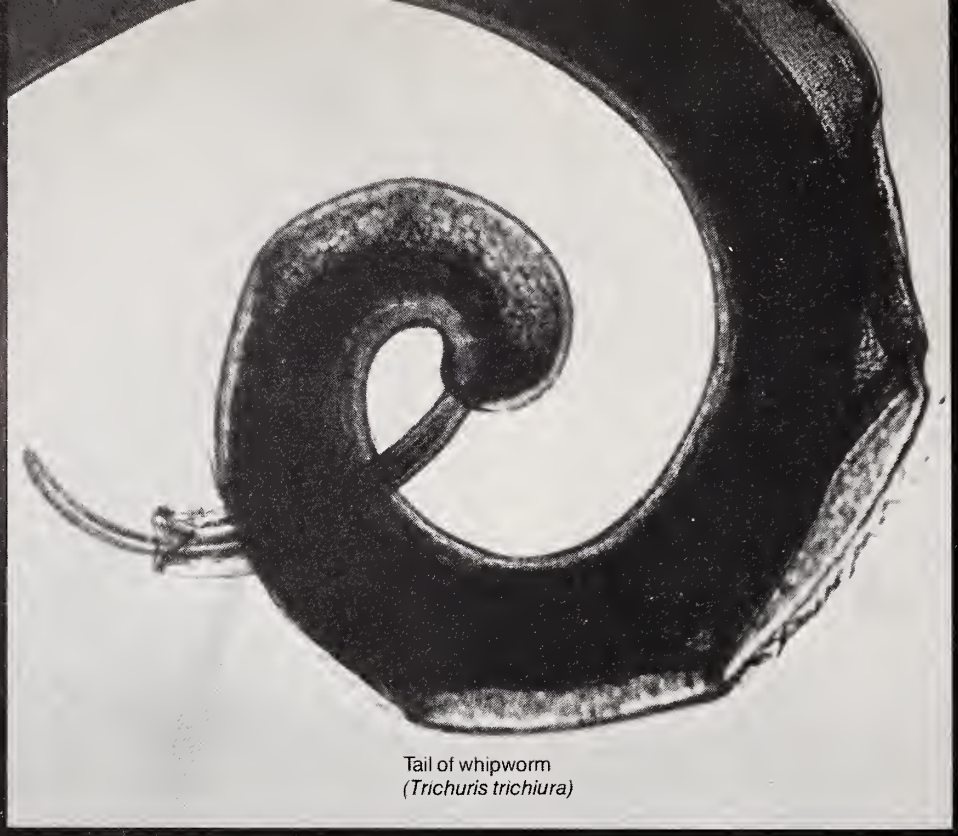
In closing, let me recount a conversation I had in New Delhi recently with Mr. Rabi Ray, the Minister of Health of India, a brilliant, articulate, and charismatic leader. I asked him for his and India's reaction to the goal of "Health for All by the Year 2000." "Can it be," I queried, "a reality in India? Or is it only a dream?"

"Dr. Bryant," he answered, "if it is to be a reality it will depend not only on the technical skills of the professionals such as yourself, but also on the political support of people such as myself, and I pledge that support."

"It is only a dream?" He said, "Let us not be distracted if now it only seems to be a dream. Just as thinking about ultimate truths leads us to discover worldly truths, so dreams give rise to important and practical ideas. Finally, if 'Health for All' is only a dream, it is a dream worth having."

References

1. International Conference on Primary Health Care, Alma Ata, USSR, September 6012, 1978.
2. Bryant J. *Health and The Developing World.* Cornell Press: Ithaca, 1970.
3. Arole M, Role R. A comprehensive rural health project in Jamkhed (India). *Health by the People.* Ed Kenneth, W Newell, World Health Organization, Geneva, 1975.
4. Henderson H. Remarks at Cobb County Symposium drawing from her book, *Creating Alternative Futures, The End of Economics,* Berkeley Publishing Corporation: New York, 1978.
5. Laney JD. Welcoming Address to Cobb County Symposium on, "Can We Afford the Future?" Kennesaw College, Marietta, Georgia, April 5-6, 1979.



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

© Janssen Pharmaceutica Inc 1980

JPI-023



Broad-spectrum coverage in mixed helminthic infections

TABLETS
Vermox®
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
***21* Years' Service**

Serving the General Insurance needs of the Medical Profession for 60 years.

POTTER-HOLDEN & CO.
Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

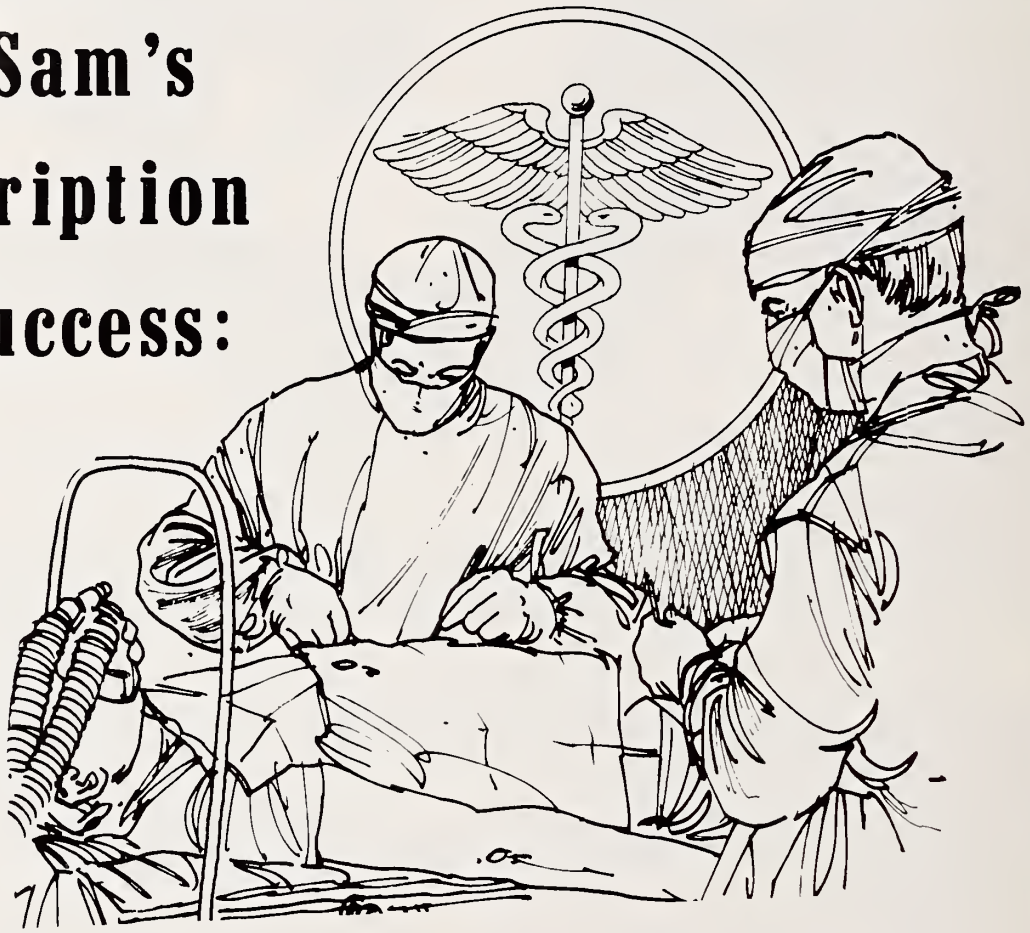
3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Insurance AGENT

Uncle Sam's Prescription For Success:



Medicine and the Ga. National Guard

As a physician in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found...service to community, state and nation.

In addition, many persons have found that the change of place and change of pace have resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for the Georgia Army National Guard units. Physicians receive monetary support for attending approved CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. **WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS.** If you need that **CHANGE OF PLACE** and **CHANGE OF PACE**, contact:

ARMY NATIONAL GUARD
The Guard belongs.

Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662

Three case histories are presented in which the undesirable side effects of jejuno-ileal bypass were improved by performing a gastric bypass instead.

Gastric Bypass: New Relief for the Undesirable Side Effects of Jejuno-Ileostomy

CHARLES E. WILLS JR., M.D., *Washington**

Introduction

JEJUNO-ILEOSTOMY for obesity was first performed by Kremans[1] in 1954 and popularized by Dewind and Payne.[2] Drenick[3] estimated that 80,000 cases of intestinal bypass surgery were performed in the United States between 1970 and 1977. Estimates of success with this kind of surgery range from 25% to 93%.[3] Most agree that 90% of the patients who have had this surgery are satisfied with the results, even though many undesirable side effects are frequently encountered, including diarrhea, proctitis, electrolyte imbalance, liver damage, arthritis, bypass enteritis, and renal stones.[4-7] Other long-term undesirable side effects recently documented are protein-losing enteritis, renal calcium oxylosis, and bone changes.[3]

No other successful surgical method was available for combating morbid obesity until the gastric bypass was introduced by Mason[8] in 1967. Early techniques of gastric bypass were reported to require 5-hour procedures and to result in weight losses that were less than those of the jejuno-ileostomy bypass. In 1977, Alden[9] introduced a revised technique for the gastric bypass using staples (auto sutures), achieving reasonable operative times and weight losses that were a little better than those resulting from jejuno-ileostomy. Since then many surgeons have preferred the gastric bypass to combat morbid obesity.

It appears that undesirable side effects, especially long-term damage, are less numerous after gastric than after jejuno-ileostomy bypass. Between May, 1977, and October, 1979, a total of 178 gastric bypasses were performed at the Wills Memorial Hospital in Washington, Georgia. Forty-eight of these were on patients who had had a jejuno-ileostomy and who subsequently experienced undesirable side effects. In these cases, the jejuno-ileostomy was taken down, and the gastric bypass was done under the same anesthetic. This paper discusses three such cases.

The Gastric Bypass Procedure[9]

Surgical procedure begins by opening the abdomen with an upper midline incision from the xiphoid to the navel. The abdomen is explored and any additional needed surgery, such as cholecystectomy, vena cava clipping,[10] umbilical hernia repair, sterilization, and liver biopsy can be done at that time. Exposure is obtained using a self retaining retractor with deep blades and the Hepco upper hand retractor under the rib cage. The triangular ligament of the liver is divided, and the liver is retracted to the right using a malleable ribbon retractor attached to the "upper hand" bar. The esophagus is mobilized. The upper half of the greater curvature of the stomach is mobilized by dividing its vascular attachments. A TA-90 stapler using 4.8 mm staples is applied across the fundus of the stomach at a point approximately 5 cm from the esophagus on the lessor gastric curvature and 8 cm from the esophagus on the greater gastric curvature. The capacity of the upper gastric

* Dr. Wills is from the Department of Surgery, Wills Memorial Hospital, Washington, GA. His address is 121 Gordon St., Washington, GA 30673.

pouch is measured to contain 50 ml. The staple line is interwoven with 3-0 chromic gastrointestinal sutures in an effort to reduce staple line breakdown. A loop of jejunum is brought anterior (or, if necessary, posterior through the mesentery of the transverse colon) to the transverse colon and anastomosed side-to-side to the small upper gastric pouch using the G.I.A. stapler set at 2 cm. The size of this anastomosis is calibrated with a Hagar dilator to measure 12 mm in diameter. A size 20 French T drain is placed through a stab wound in the afferent loop of the jejunum and secured with two purse-string sutures of 2-0 plain catgut. One end of the T-tube is then threaded upward through the gastrointestinal anastomosis into the upper small fundal pouch. The other end of the T-tube is pointed downward toward the Ligament of Treitz. The end of the T-tube is brought out through a stab wound in the left upper quadrant of the abdominal wall. On patients who have had preoperative heartburn, however, a Roux-en-Y modification is performed.

Case Histories

Case #1

This patient was a 46-year-old white man, 162 cm (64 inches) in height, and weighing 112 kilograms (246 pounds). Between 29 and 46 years of age, his weight increased from 61.5 kilograms (135 pounds) to 112 kilograms (246 pounds) in spite of repeated medical efforts to effect successful weight control. Six years previously, diabetes mellitus had been diagnosed, and he had been placed on tolbutamide (Orinase). At that time also, x-rays revealed a hiatal hernia and an acute duodenal ulcer which responded to medical therapy. Preoperatively, his triglycerides were 410 mg/100 ml (normal 50-150 mg/100 ml). In January, 1973, a 35 cm (14 inch) and 10 cm (4 inch) end-to-side jejuno-ileostomy was performed. A Teflon Inferior Vena Cava Partial Occlusion Clip was applied prophylactically to prevent pulmonary embolus. His liver biopsy showed moderate fatty metamorphosis.

Postoperatively, his triglycerides were recorded at 130, 146, and 93 mg/100 ml. The patient's weight leveled at 61.5 kilograms (135 pounds), and his bowels moved three to six times a day without medications. He was pleased with the results until 1975 when troublesome symptoms developed. He did not feel well and complained of general muscular tenderness with stiffness and soreness when inactive that became worse after heavy physical activity. His serum potassium level was 3.0 meq/liter (normal 3.8 meq/liter to 5.0 meq/liter). His symptoms responded temporarily to intravenous electrolytes; oral supplementation was inadequate. Metrenidazole (Flagyl) produced no relief from the symptoms. In 1977, after 2 years of "not feeling well," he had the intestinal bypass taken down and a gastric bypass substituted. This was done in September, 1977. His hiatal hernia was repaired at the same time. A liver biopsy demonstrated mild fatty metamorphosis and multiple small non-caseating granulomas. PAG, Giemsa, AFB, and methenamine silver stains revealed no organism. The cause of the granulomas was not apparent. He was discharged on the sixth postoperative day.

His weight dropped to 54 kilograms (119 pounds) but returned to his preoperative weight of 61.5 kilograms (135 pounds) and stabilized. The soreness in his joints has gone. He has occasional constipation but all of his previous undesirable symptoms have gone. He eats three to five meals a day of whatever he wants. When last contacted in January, 1979, he was still very pleased with the results of the gastric bypass.

Case #2

This 23-year-old white woman was 155 cm (61 inches) tall and weighed 98 kilograms (218 pounds). Her history included emotional instability, sterility, and unsuccessful weight control by conservative measures. In August, 1968, a 35 cm (14 inch) and 10 cm (4 inch) end-to-side jejuno-ileostomy was performed, after which her weight stabilized at 76 kilograms (168 pounds). Poor general health and eating habits were noted. Her serum total protein levels ranged from 5 to 6 grams/100 ml (normal 6 to 8 grams/100 ml). A liver biopsy demonstrated severe fatty metamorphosis. In February, 1971, at surgery her ovaries were wedged to counteract the effects of Stein-Leventhal Syndrome. Four inches of the jejunal segment of her jejuno-ileostomy was resected because the total segment measured 46 cm (18 inches). In July, 1974, she dieted to 55.5 kilograms (122 pounds) and became ill. She complained of abdominal swelling and epigastric pains similar to pains she had felt before her cholecystectomy in 1966. When medical therapy and diagnostic studies failed to reveal or demonstrate causes for her symptoms, she was operated on again. In November, 1975, the common bile duct was explored and adhesions were lysed; no obstruction was found. A liver biopsy was normal. During the postoperative period, the abdomen became distended. The passage of a nasogastric tube confirmed air swallowing as the cause, and the patient was taught how to avoid this. In spite of this improvement, she soon complained of troublesome diarrhea with the passing of much mucus by rectum. Metronidazole (Flagyl) caused the mucus to disappear and improved the diarrhea, but the symptoms never completely disappeared. A low grade fever, arthritis, and arthralgia responded transiently to steroids by injection. Colonoscopy confirmed a diagnosis of mucous colitis.

In October, 1977, she weighed 62 kilograms (136 pounds). Her jejuno-ileostomy was taken down, and a gastric bypass was performed. A liver biopsy was still normal. Postoperatively, she vomited frequently but a gastrografin swallow demonstrated that the gastric pouch emptied in 2 hours. She was allowed to go home 9 days postoperatively but was readmitted 17 days later vomiting bile. A diagnosis of reflux bile gastritis was made. Conservative therapy including hyperalimentation was started. Her problems continued, and 10 days later her gastric bypass was revised to a Roux-en-Y type with a gastrostomy tube in the bypassed gastric segment. Following this, a family conflict added to existing problems, and the Roux-en-Y anastomosis was temporarily obstructed. The obstruction subsided spontaneously 12 days later, and she was discharged. The gastrostomy tube was removed 10 days later when she returned as an out-patient.

Since having the gastric bypass, she has vomited several times every day. She is unable to stop eating. The mucous colitis has completely disappeared except occasionally when she has a virus. Her weight has stabilized at 45.4 kilograms (100 pounds). She continues to have poor general health and emotional habits which increase undesirable side effects. Nevertheless, when last contacted in December, 1978, she preferred the gastric bypass to being obese or to having the intestinal bypass.

Case #3

This 18-year-old white girl was 156 cm (61.5 inches) in height and weighed 127 kilograms (280 pounds). Menses occurred only three to four times a year and often lasted 2-3 weeks. Other problems were psychological and obesity related. Repeated attempts at weight control with diets and pills over a 6-year period had been unsuccessful.

On June 7, 1974, a 35 cm (14 inch) and 10 cm (4 inch) end-to-end jejuno-ileostomy was performed. Her liver biopsy demonstrated severe fatty metamorphosis. By May, 1975, her weight was down to 86 kilograms (180 pounds). Pregnancy followed with a weight gain up to 97 kilograms (214 pounds) after which her weight stabilized. Undesirable side effects included five to 10 diarrhea stools a day, intermittent rectal bleeding, pain in the back and lower extremities, and social and physical impairment. Liver biopsies in June, 1974, and May, 1975, showed moderate fatty metamorphosis. In January, 1978, mild portal fibrosis was added.

On Jan. 18, 1978, the jejuno-ileostomy bypass was taken down and a loop type of gastric bypass was performed. The undesirable effects disappeared. One year later, she said she felt great and was working two jobs. Her weight was 70 kilograms (155 pounds).

Discussion

Up until the last few years, jejuno-ileostomy bypass patients who have experienced undesirable side effects have had to try to live with them or have the bypass taken down. Essentially all cases who have the bypass taken down gain all their preoperative weight back within a short time. Now these patients may be relieved of many undesirable side effects and still maintain their weight loss by accepting the gastric bypass.

The gastric bypass also in some cases has its unpleasant side effects. Postoperative vomiting, ability to eat only small amounts, dumping syndrome, and marginal ulcers are reported to occur in a small percentage.

Jejuno-ileostomy bypass cases who are suffering from malabsorption and especially from protein deficiencies must be prepared preoperatively with hyperalimentation. This is often prolonged and expensive, but failure to do this only results in disastrous postoperative results such as anastamotic suture line breakdown, generalized peritonitis, fistula formation, and death. One cannot expect a gastric bypass case to build up metabolic deficiencies on the limited oral intake after surgery.

Postoperative vomiting is managed by aggressive counseling of the patient in food intake. Very small amounts are required to fill the small pouch. Eating meals without liquids, using high protein foods, thorough chewing, and drinking liquids between meals is recommended.

Dumping syndrome can usually be prevented by the very small gastrointestinal anastomosis stoma (12 mm), but if present, is treated by dietary counseling. Alden[9] reported an incidence of 3%.

Marginal ulcer rarely occurs because the upper pouch is low in acid-producing cells. Alden[9] reports a 1% incidence and states that ulcers are easily managed medically.

Delayed breakdown of the staple line across the fundus of the stomach has occurred in six cases. Double application of the TA-90 staples and various added suturing techniques have been tried to prevent this problem.[3]

Hitchcock[11] found better results when both procedures (taking down the jejuno-ileostomy bypass and doing the gastric bypass) were performed at the same time in preference to doing them separately several months apart.

Long-term follow-up checking is needed in both procedures and daily multiple vitamin supplements are advised; however, nutritional deficiencies are rarely seen.[12]

Jejuno-ileostomy bypass patients who lose weight and then gain it back usually get good additional weight loss after conversion to gastric bypass. Jejuno-ileostomy bypass cases who initially get poor

weight losses are not as likely to get good weight losses with gastric bypass.

Twelve cases of granuloma (caseating and non-caseating) of the liver have been encountered by the author in a series of 794 jejuno-ileostomy cases over a 15-year period. Many of them have been studied but causes have rarely been found. No ill effects have been seen in any cases.

References

1. Kreman AJ, et al. An experimental evaluation of the nutritional importance of proximal and distal small intestine. Ann Surg 1954;140:439-448.
2. Payne JH. Metabolic observations in patients with jejuno-colic shunts. Am J Surg 1963;106:273.
3. A Consensus Development Conference on Surgical Treatment of Morbid Obesity. National Institutes of Health, Bethesda, Maryland, December 4-5, 1978.
4. Wills CE Jr. Managing the complications of jejuno-ileostomy. JMAG 1976;65:415-417.
5. Shagrin JW, et al. Polyarthritis in obese patients with intestinal bypass. Ann Int Med 1971;75:377-380.
6. Weissman RE. Surgical palliation of massive and severe obesity. Am J Surg 1973;125:437-446.
7. Wills CE Jr. Small bowel obesity, a discussion of four different procedures. JMAG 1972;61:322-328.
8. Mason EE, Its C. Gastric bypass in obesity. Surg Clinics of NA 1967;47:1345-1351.
9. Alden JF. Gastric and jejuno-ileal bypass. Arch Surg 1977;112:799-806.
10. Wills CE Jr. The prevention of mortality following intestinal bypass for obesity. JMAG 1974;63:389-393.
11. Hitchcock CT, et al. Management of the morbidly obese patient after small bowel bypass failure. Surg 1977;82:356-361.
12. Mason EE, et al. Optimizing results of gastric bypass. Ann Surg 1975;182:405-413.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

TEGA-SPAN CAPELLETS

FOR MORE ADVANCED NICOTINIC ACID THERAPY

Each capsule contains: . . . 400 mg of pure pelletized Nicotinic Acid

INDICATIONS: Tega-Span is indicated where reduction of serum cholesterol and total lipid levels in hypercholesteremia and hyperlipemia is desirable. It may also be useful in reducing xanthomatous tissue cholesterol deposits.

DOSAGE AND ADMINISTRATION: Usual dose is one or two capellets twice daily with or after meals. Since lower doses may control hyperlipidemia in some patients, the dosage should be individualized according to the effect on serum lipid levels. It is also to be noted that adverse reactions appear with great frequency early in therapy; in order to avoid these, it may be best to start the drug at low levels and increase dosage gradually.

Federal Law prohibits dispensing without a prescription

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTABLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

REG. NO.

THE DEVEREUX FOUNDATION

ARIZONA
CALIFORNIA
CONNECTICUT
GEORGIA
PENNSYLVANIA
MASSACHUSETTS
TEXAS
ARKANSAS

M..... DATE.....

Age Pre-Adolescents Adolescents & Young Adults

℞

HEDGES TREATMENT CENTER

Intensive psychiatric care for youths and young adults in transition, those who are not fully ready to utilize a conventional residential treatment approach but whose problems are not severe enough to warrant psychiatric hospital attention.

..... M.D.

℞ Age 17-24

CAREER HOUSE

For intellectually bright high school graduating seniors, and post-high school youth with problems of underachievement and/or personal adjustment. Psychotherapy, academic and vocational counseling. Arrangements made for enrollment in local colleges and career schools.

..... M.D.

Age Under 10

℞

CENTER FOR AUTISTIC AND SCHIZOPHRENIC CHILDREN

A comprehensive, short-term, residential treatment program for severely disturbed children under ten years of age.

..... M.D.

℞ Age Adolescents and Adults

EDWARD L. FRENCH REHABILITATION CENTER

C. A. R. F. Approved

Residential and day programs. Comprehensive vocational evaluation, training and placement services. Opportunities for social adjustment training, work adjustment training, and sheltered employment.

..... M.D.

. . . And many more separate day and residential treatment programs **prescriptively planned** for children and young adults with emotional and mental disabilities

Helena T. Devereux
Founder

Joseph B. Ferdinand
President

Charles J. Fowler
National Director of Admissions

FOR INFORMATION AND LITERATURE:

PENNSYLVANIA Ellwood M. Smith, Admissions Director, Devon, Pa. 19333 or call 215 687-3000
CALIFORNIA Keith A. Seaton, Admissions Director, Box 1079 Santa Barbara 93102or call 805 968-2525
TEXAS Robert E. Worsley, Admissions Director, Box 2666, Victoria 77901 or call 512 575-8271
ARIZONA Richard A. Etter, Director, 6436 E. Sweetwater, Scottsdale 85254 or call 602 948-5857
GEORGIA Ralph L. Comerford, Director, 1980 Stanley Road, N. W., Kennesaw 30144 or call 404 427-0147
CONNECTICUT Theodore E. Enoch, Director, Sabbaday Lane, Washington 06793 or call 203 868-7377
MASSACHUSETTS Frederic A. Hervey, Director, Miles Road, Rutland 01543 or call 617 886-4746

. . . Carrying the Promise of Happy Tomorrows



THE DEVEREUX FOUNDATION

A NONPROFIT ORGANIZATION

All Devereux Branches Surveyed by the Joint Commission on Accreditation of Hospitals are Approved as Psychiatric Facilities for Children and Adolescents

editorials
editorials
editorials

"The kind of pleasure and understanding that I get from studying natural history has long vanished from most contemporary teaching institutions that have become part of intensive care units, which are supposed to save the residual intellectual machinery of medical students. The teeming mass of hope and pain, technical virtuosity, and depersonalization called a "health center" delivers packets of what is termed "medical care." The capacity to look remains, but the capacity to see has all but vanished. Teachers and students forget that the ability to palpate is not the same as the ability to feel."

William B. Bean, M.D., "Nail Growth — Thirty-five Years of Observation"
Arch Intern Med 140:73, 1980

To Comfort Always

"To cure sometimes, to relieve often, to comfort always." This quotation appears on the statue erected in honor of Francis Trudeau at Saranac Lake, New York. These few words summarize the physician's primary obligation in his practice of medicine.

In this age of antibiotics, increasing specialization, and laboratory medicine, many of us tend to lose sight of our primary responsibility in the care of our patients. Regardless of how specific our diagnostic and therapeutic aids may become, we still must be willing and able to communicate effectively with our patients if we are to function effectively in the healing process of the sick.

Scientific knowledge has become indispensable in the modern physician's armamentarium, and no one can be a good doctor today without competent and adequate scientific training. But more is needed to practice good medicine, which has remained an art while continuing to expand as a science. It is today a far-advanced science. But in addition — it has always been and will always be — an art. The secret of healing derives not only from knowledge but also from the human qualities of the healer as well. That physicians of the eighth decade of the twentieth century should have to discover that man has a psyche as well as a soma is a travesty on modern medicine. In spite of this apparent "new discovery," many of us still give only lip service to the emotional aspects of the problems of our patients.

There are plenty of capable physicians. What we need are more physicians who are nice to people. To some, this art seems to be inherent; to others, it has to be consciously learned. We frequently look askance at those members of our profession who have developed the art of being nice to people to such a high degree while allowing their scientific knowledge to deteriorate. These individuals invariably have highly successful practices much to the dismay and chagrin of their more scientifically oriented colleagues. The patients of the former physicians are unusually loyal. Because of our disdain for the professional qualifications of this type of physician, many of us swing rather far in the opposite direction. We sometimes

erroneously associate the quality of being "too nice" to our patients with professional mediocrity. Nothing could be farther from the truth.

Indeed, one gets the impression when talking with an occasional consultant that he dare not be "too nice" to the patient lest his standing as a consultant be questioned. These individuals, fortunately, are rare. The fact remains that in our training in scientific medicine, the art of being nice to patients is insufficiently stressed. Without this ability to acquire a mature rapport with our patients our best scientific knowledge cannot be utilized. It seems ironic that as our scientific knowledge is advancing at such a rapid rate our appreciation of the art of communication as a rubric of good medical care is diminishing with alarming rapidity. Are our viewpoints too limited to encompass the whole picture? Let us not miss the boat in our zeal for more scientific understanding of disease and lose the very foundation of medical practice — patient understanding. With this quality, the practice of medicine as we know it can withstand any storm. Without it, patients and doctors alike will remain adrift in an isolated sea of misunderstanding and mistrust.

Edgar Woody Jr., M.D.

"Health for All" — Another Viewpoint

THE PUBLICATION of Dr. James Bryant's paper, "Can We Afford the Future," in this issue of the *Journal of the MAG* is very appropriate. I attended the Cobb County Symposium when this paper was presented in April, 1979, and was impressed by its message. After reading it subsequently, however, I feel that an extremely important message was delivered but inadequately perceived. Dr. Bryant and the Department of Health, Education, and Welfare have committed our country to a most ambitious joint project with 141 other nations of the world. They subsequently affirmed commitment to that concept ("Health for All by the Year 2000") in January, 1979, at a meeting of the Executive Committee of the World Health Organization. It is important that all are aware of the goals expressed in this Declaration and the means of achieving them. I would solicit your careful attention to both.

The United States has characteristically demonstrated generosity in its relationships to former adversaries (i.e., Germany and Japan) as well as to the needy of *any* country. The U.S. Congress has consistently voted our country's support for the needy, and individually, our citizens have given generously via private organizations. The commitment described in this paper represents a dramatic change for our country, by which we join efforts of the "world community" to solve social problems. The autonomy of individual action we have enjoyed in the past will be obsolete as we participate in the "New International Economic Order, the movement on the part of the less-developed countries to achieve a fairer share of the world's economy, particularly in relation to international trade."

This dramatic change described in Dr. Bryant's presentation has not been a position adopted as a result of our usual legislative process but rather is one adopted by a branch of the administration with little debate. The "Declaration of Alma Ata" is a broad definition of primary health care which encompasses nearly all basic human needs and could well be described as a major part of the "New International Economic Order." I suspect our country would cooperate with individual countries as they address their problems of health care but might well be less than enthusiastic with the "opportunity of being a participant, an important participant, but a humble participant," in the world community project.

Harrison L. Rogers Jr., M.D.
1938 Peachtree Rd., NW
Atlanta, GA 30309

allergy unmasked

A NEW UNDERSTANDING

MULTIMEDIA CONTINUING EDUCATION PROGRAM



At last...
A program that tells how new views on allergy can be used in daily practice

Nine international authorities discuss new views of allergy and developments that make diagnosis more precise, treatment more practical for all concerned physicians. Available *free of charge,* as a service to the medical profession from PHARMACIA Diagnostics, the complete program includes:

FILM (OR VIDEO CASSETTE) –
25-minute presentation relates new views on allergy through actual case histories.

COMPREHENSIVE PACKAGE –
Also supplied are moderator's guide, self-assessment tests, announcement posters, accreditation information. Present ALLERGY UNMASKED to colleagues, students, other health professionals at the time and place of your choice. For more detailed information, simply return the convenient coupon.

MONOGRAPH –
72-page illustrated text provides in-depth discussion of theory and application for home study.

PHARMACIA Diagnostics
Division of Pharmacia Inc.
800 Centennial Avenue,
Piscataway, NJ 08854

SJ



☐ Please provide more information on the ALLERGY UNMASKED Continuing Education Program.

☐ Please have a representative contact me.

Name (please print) _____

Title _____

Organization _____

Address _____

City _____

State _____ Zip _____

Pharmacia Diagnostics
Division of Pharmacia Inc.
800 Centennial Avenue
Piscataway, NJ 08854

Copyright © Pharmacia Inc. 1979

Pharmacia Diagnostics

9-054IM

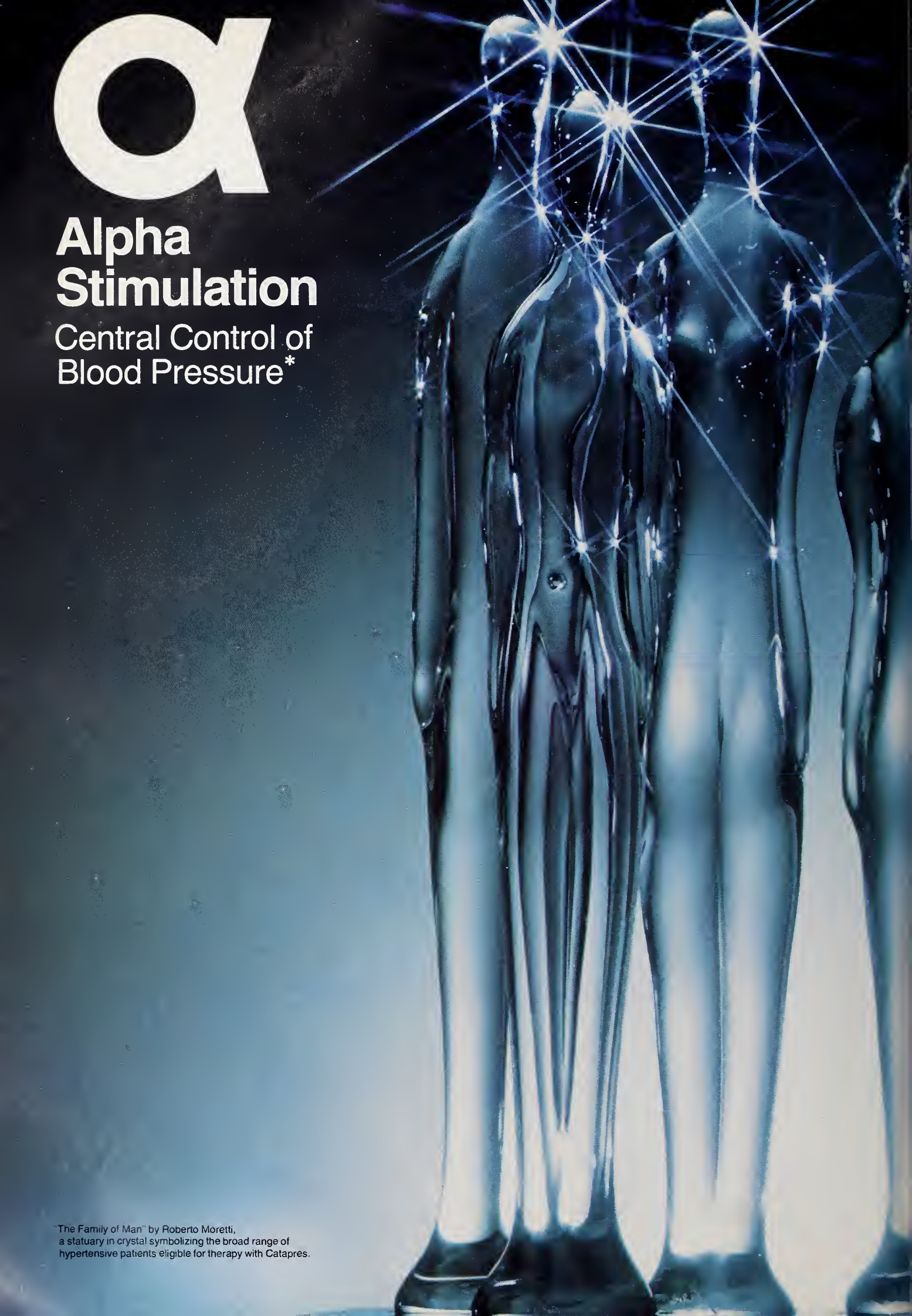


How Supplied:
Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

SK&F LAB CO.
a SmithKline company

Alpha Stimulation

Central Control of Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets

Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension



The Alpha Advantage:

It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

BOEHRINGER INGELHEIM

Boehringer Ingelheim

Boehringer Ingelheim Ltd
Ridgefield, CT 06877

State-Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgment

THOMAS D. HARPER, *Atlanta**

ONE OF THE MOST politically volatile issues of the late 1970s was whether abortions should be available on demand. After a series of judicial decisions recognizing a woman's right to secure an abortion in specific instances, the focus of the debate shifted to whether the state or federal government should finance abortions for women who cannot afford to pay for them. The United States Congress has affirmatively established its desire to avoid federally-financed abortions, but these intentions have come under increasing attack. The recent case law has recognized a right to a federal or state-financed abortion in instances where the patient is able to secure a physician's opinion that the operation is "medically necessary." The hallmark of the recent decisions has been an unprecedented recognition that the "medical necessity" of an abortion is a decision which must be determined solely by the woman's personal physician in consultation with the patient.

Background

In attempting to legislate the legal availability of abortions, Congress and, to a lesser extent, the state legislatures have recognized their lack of expertise in drafting criteria for the performance of therapeutic ("medically necessary") abortions. After being prodded by the courts, the legislatures have concluded that they must leave the answering of medical questions to the medical profession.

The U.S. Supreme Court has authorized varying degrees of state regulation of abortion availability according to three judicially recognized stages of pregnancy. Prior to the end of the first trimester, the decision rests solely with the pregnant woman and her attending physician, without interference from the state. During the second trimester, a state may, if it chooses, reasonably regulate the availability of the abortion procedure to preserve and protect maternal health.

In the final trimester, the beginning of which is determined by fetal viability,[1] the state may regulate the availability of an abortion to protect the life of the fetus and may completely prohibit abortion "except where it is necessary, in appropriate medical judgment," for the preservation of the life or health of the mother.[2] According to the Supreme Court, the physician, in exercising his or her "appropriate medical judgment," may include physical, emotional, psychological, familial, and personal factors relevant to the well-being of the individual patient.[3] The primary consideration at all times is the physician's conclusion as to the "medical necessity" of an abortion.

* Prepared at the request of the Medical Association of Georgia. Mr. Harper is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

Faced with this expanding judicial recognition of the right to an abortion, the anti-abortion or "Right-to-Life" groups have attempted to secure a limitation of federal financing of abortions. Title XIX of the Social Security Act, as amended in 1965, established a general framework for medical assistance to families "whose income and resources are insufficient to meet the cost of necessary medical services."[4] Attempts to amend this provision to exclude federal funding for abortions, like the attempts to amend the U.S. Constitution to prohibit all abortions, failed. Anti-abortion groups were, however, successful in pressing Congress to enact a limitation upon expenditures for abortions in the form of yearly restrictions in appropriations bills. The relevant restriction, which has appeared in the Departments of Labor and Health, Education, and Welfare Appropriations Acts since 1976, is known as the Hyde Amendment.[5]

Constitutional Attacks Against the Hyde Amendment

The U.S. Supreme Court has recognized that nothing in Title XIX requires participating states to fund every medical procedure which falls within categories delineated by the Act. The Court recognized, however, that a state plan is subject to serious problems if it excludes any *necessary* medical treatment.[6] Although the Constitution imposes no obligation on a state to pay the medical expenses of indigent women, when a state does provide medical care for the impoverished (including pregnancy-related treatment), the manner in which it dispenses benefits is subject to constitutional limitations.[7]

In *Roe v. Wade,* the U.S. Supreme Court recognized that abortions during the first trimester could not be restricted where the patient's personal physician made a finding that the abortion was "medically necessary" through a consideration of physical and nonphysical factors. As to state-funded abortions, however, the Hyde Amendment requires a certification by more than one physician of life endangerment or long-lasting physical health damage. The different criteria for abortions for the indigent ("life endangerment") and for persons capable of financing their abortions ("medically necessary") led several courts to question the constitutional validity of the Hyde Amendment.[8]

In January, 1980, the U.S. District Court for the Eastern District of New York declared the Hyde Amendment unconstitutional.[9] Although the decision mentioned the violation of a pregnant woman's First and Fifth Amendment rights, the consideration most heavily emphasized by the Court was the failure of the legislation to provide a physician with the necessary freedom to make appropriate decisions concerning the woman's health. The Court noted that the U.S. Supreme Court has approved statutory reliance upon the attending physician's "best clinical judgment that an abortion is necessary" as providing sufficient safeguards to protect societal and individual interests in the abortion process. In addition, the courts have repeatedly recognized the necessity of relying upon the insurance given by a physician's license that the physician possesses the requisite qualifications for making judgments concerning necessary medical care.[10]

Viewed against this background, the medical deficiencies of the Hyde Amendment were held to be numerous. The Amendment was held to be constitutionally deficient because the propriety of a federally-funded abortion was determined by language not commonly utilized in the medical profession; the legislative standards would be functional only in a crisis intervention situation when different physicians would have different opinions in predicting potentially life-threatening conditions. The court concluded that the consequential professional reluctance to certify the requisite necessity under an alien medical standard would inevitably result in a denial of medical assistance. The "medical necessity" for an abortion was held to be "inescapably a medical question" which could not be restricted by legislation. By invoking such a restriction, the Congress was held to have acted in an unconstitutional manner.

Within the state of Georgia, a federal district court has held Hyde Amendment-type rules promulgated by the state Department of Medical Assistance to be

violative of the state's obligations under Title XIX.[12] The court did not reach the issue of the constitutionality of the Hyde Amendment because the court concluded that state participation under Title XIX required state funding of "medically necessary" abortions regardless of federal willingness to reimburse the state for its expenditures.

The Sanctity of the Physician's Medical Judgment

Although appeals are either pending or anticipated in relevant cases, the most significant development in the debate over government-funded abortions is the willingness of pro-abortion forces to delegate to physicians the authority for deciding the propriety of individual abortions. The U.S. Supreme Court has reflected a continued and growing willingness to yield to the medical profession in determining the necessity for an abortion-for-pay in the initial term of the pregnancy. The lower federal courts have seized upon this fact to justify their conclusion that the physician, in consultation with his patient, retains a similar authority in government-financed abortions. The federal judiciary has established a clear intent to reject the medical judgment of a legislator and to rely upon the reasoned conclusion of the individual physician as he or she acts in the exercise of his or her best medical judgment.

Notes

1. "Fetal viability" has been defined as the stage at which the fetus is potentially capable of life outside the mother's womb, albeit with artificial aid. *Planned Parenthood of Missouri v. Danforth,* 428 U.S. 52, 63 (1976). This stage may, of course, be achieved at different times in the development of different fetuses. The sixth month was referenced only for ease of discussion.
2. *Roe v. Wade,* 410 U.S. 113, 163-65 (1973).
3. *Doe v. Bolton,* 410 U.S. 179, 192 (1973).
4. 42 U.S.C. §1396 (1973).
5. Pub. L. No. 95-480, 92 Stat. 1567, 1586 (1978). Since 1977, the Hyde Amendment has provided, in relevant part: None of the funds provided for in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service; or except in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.
6. *Beal v. Doe,* 432 U.S. 438, 444 (1977).
7. *Maher v. Roe,* 432 U.S. 464, 469-70 (1977).
8. See, for example, *Zbaraz v. Quern,* 596 F.2d 196 (7th Cir. 1979); *Preterm, Inc. v. Dukakis,* 591 F.2d 121 (1st Cir. 1979).
9. *McRae v. H.E.W.,* No. 76-C-1804 (E.D.N.Y. January 15, 1980), *review granted, sub nom. Harris v. McRae,* 48 U.S.L.W. 3514 (1980) (No. 79-1268).
10. *Doe v. Bolton, supra,* 410 U.S. at 199-200; *Dent v. West Virginia,* 129 U.S. 114, 122-23 (1889).
11. *McRae v. H.E.W., supra* at 91, 99, and 160.
12. *Doe v. Busbee,* 471 F.Supp. 1326 (N.D. Ga. 1979), *appeal pending.*
13. See, Billing Procedures and Reimbursement Policies for Physicians Services — Appendix D (revised 12/1/78).



Pain is the necessary contrast to pleasure; it ushers us into existence or consciousness: it alone is capable of exciting the organs into activity: it is the compassion and the guardian of human life.

Sir Charles Bell

Practice what we teach

Today there are over 31 million men, women and children suffering from the many forms of arthritis and related rheumatic diseases. And there just aren't enough trained rheumatologists to help them.

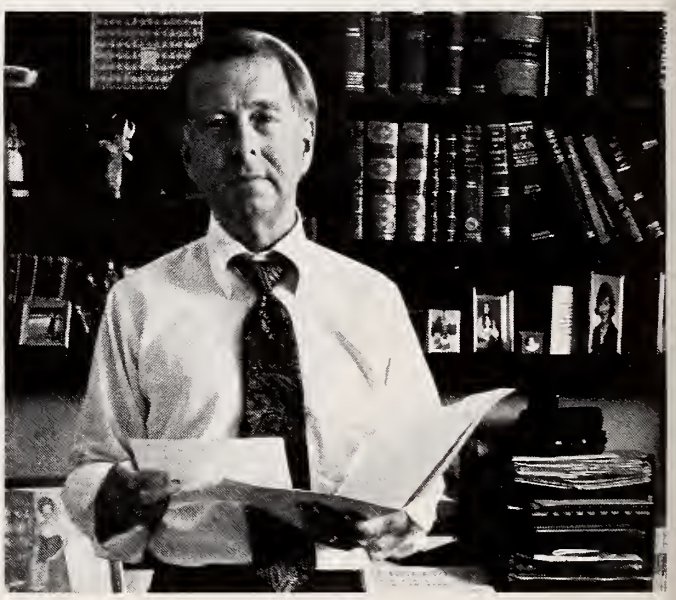
That's why arthritis sufferers need your help.

They must depend heavily on the family practitioner for better diagnosis, more effective patient treatment.

Contact your local Arthritis Foundation chapter for the latest information on arthritis. This includes continuing educational seminars by leading rheumatologists, scientific meetings, "outreach" programs—as well as the "Bulletin on the Rheumatic Diseases," "Arthritis and Rheumatism Journal," "Primer on the Rheumatic Diseases," audio cassettes and other professional materials. Free disease handbooks and medication pamphlets are also available to patients.

Please. Let us help your practice with what we teach.

The Arthritis Foundation helps doctors help.



ARTHRITIS FOUNDATION.

A public service of this magazine.

Carbon Dioxide Laser in Gynecology

MATTHEW O. BURRELL, M.D., *Atlanta**

FROM ITS INCEPTION in 1960, the laser (light amplification by the stimulated emission of radiation) has played a burgeoning role in industry and medicine. Since the invention of the carbon dioxide (CO^2) laser in 1965 and the refinements of an articulating arm, combined with the usefulness of a colposcope, there has been an increasing interest in the gynecologic applications of this treatment modality. It should no longer be considered experimental and deserves a unique place in the armamentarium of the gynecologist.

Physics

Albert Einstein first postulated that electromagnetic radiation could be stimulated. Once the practical application of this concept was achieved in 1954 with the maser (microwave amplification by the stimulated emission of radiation), it was a short step to the theoretical and practical applications of the laser in 1958 and 1960. Although a multitude of liquid, gas, and solid compounds can be used as a lasering medium, a simplified version of what happens is illustrated by the CO^2 laser. Into an oblong vacuum chamber, carbon dioxide is infused along with trace amounts of helium and nitrogen, which act as catalysts. An energy source, in this case a direct electrical current, is passed through the mixture in a longitudinal fashion. The carbon dioxide atoms are quickly excited to a higher potential energy known as the "excited state." When most of the atoms are in this state, a "population inversion" is said to exist. With further stimulation, packets of photons of energy are released. Since all the "excited state" atoms have the same potential energy, the energy of all the photons released is the same. For the CO^2 laser, each photon has a wave length of 10.6 microns. Each photon also has the property of stimulating emissions so that, in effect, a chain reaction occurs. At either end of the resonating chamber, concave mirrors reflect all incident photons along a longitudinal tract. A pinhole-size area at one end of the tube allows the eventual output of the undirectional photons. The resulting laser is almost perfectly parallel. These properties of monochromicity, parallelism, and coherence (all waves are in phase), allow for a precise delivery of energy to a target. Just as the focusing of the nearly parallel light rays from the sun can ignite paper, the focusing of the nearly parallel CO^2 laser beam can result in enormously high temperatures.

The two main American manufacturers of lasers, Cavitron and Coherent, produce a focused beam of between 1.5 and 2 mms. The power, that is, the number of protons in a laser beam, is measured in watts and can be varied. When coupled with a colposcope, the laser beam can be directed to small, precisely defined lesions.

* Dr. Burrell practices gynecologic oncology. His address is 5669 Peachtree-Dunwoody Rd., NE, Ste. 100, Atlanta, GA 30342.
Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

Cell destruction occurs essentially by the evaporation of the intracellular water. The conduction of heat is essentially that of water, with 90% being absorbed within the first 30 microns of tissue. At higher energy densities, that is, 1,250 watts per cm^2 (25 watts in a 2 mm beam), incision of tissue occurs with lateral necrosis of no more than 50 microns. At lower energies of less than 100 watts per cm^2, and particularly when the beam is defocused and applied over a period of time, necrosis occurs perhaps of up to 600 microns. This latter mode of application is useful for coagulation.

Uses in Gynecology

Fundamental to the acceptance of any localized therapy for the intraepithelial neoplasias, is the acceptance of the underlying pathologic concept. As formulated by Richart,[1] cervical intraepithelial neoplasia represents a continuum of changes, all grades of which can be controlled by local means. Well-documented follow-up studies with the use of cryosurgery have shown that local destruction by freezing results in the same low primary failure and recurrence rates regardless of grade. The only factor influencing recurrence is the geographic extent of the lesion. It is, therefore, inconsistent to insist upon a conization or hysterectomy for carcinoma in situ (CIN III), and local destruction for mild to moderate dysplasia (CIN I-II). The analogy holds true for intraepithelial neoplasias of the vagina and vulva, although the malignant potentials there have not been well established.

In fact, wherever the cryosurgery probe can be placed, so can a laser beam, with equal success. The fundamental rules of colposcopy, however, must be followed: 1) satisfactory colposcopy, that is, visualization of the whole lesion at risk; 2) concurrence of cytology, endocervical biopsies, and biopsies of the worst-appearing areas; 3) an experienced colposcopist; and 4) adequate follow-up for at least a year.

Kaplan[2] first described the colposcopically attached laser as a means of destroying cervical erosions in 1973. No concurrent data on the presence of cervical intraepithelial neoplasia were given. In this country, Upton in 1975,[3] Stafl, and Mattingly,[3] as well as Carter[4] in 1978, reported their experiences in the treatment of all grades of CIN (mild to moderate dysplasia, severe dysplasia, and carcinoma in situ). A primary failure rate of between 6.7 and 15.5% was reported. The greatest experience is that of Bellina,[5] who reported that with appropriate retreatment in over 200 patients, the recurrence rate can be reduced to 3.5%. This is essentially the same as can be achieved with conization or cryosurgery.

Following the introduction of the Coherent 400 CO^2 laser at Saint Joseph's Hospital in Atlanta in January, 1978, our group has been most impressed with its advantages. Some authors have maintained that there is no distinct advantage of the laser in treating cervical lesions.[6] As with cryosurgery, the laser can be used without anesthesia on an out-patient basis. Unlike cryosurgery, however, the amount of unnecessary tissue destruction can be minimized. The squamo-columnar junction, so important for adequate colposcopic follow-up, is maintained. No cervical stenosis occurs, and of most concern to the patient, vaginal discharge does not last over 5 days. Cervical hemorrhage is usually less than 5 ccs. and easily controlled. Complete healing is amazingly rapid with only a moderate erythema 2 weeks later. The lack of necrosis with subsequent infection makes it suitable for the treatment of lesions in the presence of an intrauterine device and, if absolutely necessary, in the presence of pregnancy. Broad areas of cervical intraepithelial neoplasia are much more reliably destroyed than with the multiple applications of the cryosurgical probe. Concern has been raised recently regarding the reliability of a constant freezing temperature and, therefore, of a constant depth of freezing of the cryosurgical probe. We have found that with the laser, we can be absolutely certain of the depth of destruction, which is so important for the prevention of recurrence arising from the endocervical glands.

Experience with vaginal intraepithelial neoplasia is less well documented. Total published cases number about 40, with recurrences in two. In the previously

irradiated or the surgically altered vagina, the control of depth is all important. However, due to the 100° Centigrade temperature generated, pain is more consistently felt in the vagina than on the cervix. Successful analgesia can be accomplished with local infiltration, something difficult to achieve with cryosurgery. We have found that the uneven surfaces of the vaginal adenosis in the diethylstilbestrol (DES)-exposed patient cannot adequately be destroyed with any modality other than the laser. The lack of scarring following therapy in these young patients is of paramount consideration.

Because of the multifocal nature of vulvar intraepithelial neoplasia, local destruction may be followed by multiple recurrences. Experience with the laser for this disease is no different from that of surgery, but unlike surgery, no deforming scarring results, and retreatment is no problem. The more adventurous therapists are now lasering whole vulvas for a variety of lesions, including vulvar intraepithelial neoplasia, vulvar dystrophies, herpes vulvitis, and condylomata. The first 3 to 4 days are relatively pain-free, as if nerve endings were seared. Thereafter, considerable vulvar discomfort occurs, lasting approximately 2 weeks. Ultimately, patients are pleased with the end result of a vulva free of scars, stenosis, or deformity.

Some Practical Problems

Common to other laser centers, we have charged patients according to the procedure performed, that is, conization, partial vulvectomy, local excision, rather than whether the laser or the scalpel was used.

The cost of the laser unit, $20,000 to $30,000, can only be justified by treating a high volume of patients. Each treatment is obviously more expensive than cryosurgery, but less than the attendant costs of scalpel surgery. Nevertheless, following a full explanation of all the economic and therapeutic factors for each available treatment modality, the majority of our patients have chosen laser surgery.

References

1. Richart RM. Cervical and intraepithelial neoplasia: a review. In Path Annual 1973, a monograph (Ed) Summers SC, Appleton Century Crofts: New York.
2. Kaplan I, Goldman J, Ger R. The treatment of erosions of the uterine cervix by means of the CO^2 laser. Obstet Gynecol 1973;41:795-796.
3. Stafl A, Mattingly RF. Laser treatment of cervical and vaginal neoplasia. Am J Obstet Gynecol 1977;128:128-136.
4. Carter R, et al. Treatment of cervical intraepithelial neoplasia with the carbon dioxide laser beam. Am J Obstet Gynecol 1978;131:831-836.
5. Bellina JH. Gynecology and the laser. Contemp Ob-Gyn 1974;4:24-34.
6. Cibley LS. The laser in gynecologic surgery. Female Patient 1980;Jan:72-79.

president's letter



I Had a Dream

I DREAMED THAT in the 1980s the United States and Russia made peace and started a disarmament program that would guarantee that the world would not be annihilated by nuclear warfare.

Also, President Carter balanced the national budget, halted inflation, and the United States regained its former respect. Senator Kennedy finally saw the light and recognized that our medical system really is the best in human history. He put our patients first and stopped his popularity quest with National Health Insurance.

In my dream, the labor unions started giving a day's work for a day's pay, enabling us to build a better and cheaper mousetrap so we could stop importing them from Japan. We also began walking more, riding MARTA, and driving less, with gasoline plentiful at 25¢ per gallon.

Governor Busbee brought all his board appointments up to date — even the State Board of Medical Examiners — and the licenses of all the bad doctors were revoked.

Mayor Jackson appointed the best qualified persons in city government and, as crime declined in Atlanta, prosperity increased, and we became too busy to hate, rape, rob, or kill.

I dreamed that all M.D.'s in Georgia, even residents, were members of their respective county medical societies, the MAG, and the AMA. We began caring so much about and for our patients that excellent medical care was available to all Georgians at a reasonable cost.

This dream can become a reality in the 1980s.

It starts with you and me waking up and facing the present-day realities so we can begin to effect positive change in the future for the good of all.

Good-bye,

Sincerely,

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

NEW MEMBERS

Almeroth, Robert H., Jr., DeKalb—N1—FP
462 Montreal Rd., Tucker 30084

Audo, Stephen P., MAA—N2—GS/ON
81 Upper Riverdale Rd., Riverdale 30274

Brahn, George R., Peach Belt—N2—GS
05-B Briarcliff, Warner Robins 31093

Branitz, Bruce H., Gwinnett-Forsyth—N2—U
719 Scenic Hwy., SW, Lawrenceville 30245

Halper, Robert, MAA—ACT—DR
35 Collier Rd. NW, Ste. 805, Atlanta 30309

Hull, James D., III, Douglas—N2—GS
3954 Hospital Dr., Ste. 105-C, Douglasville 30134

Hurst, John W., Jr., MAA—N1—CD/IM
3280 Howell Mill Rd. NW, Ste. 133, Atlanta 30327

Zaworski, Robert E., MAA—N2—PS
1938 Peachtree Rd. NW, Ste. 701, Atlanta 30309

PERSONALS

First District

Herbert R. Frost, M.D., of Swainsboro, was recently named chief of staff of the Emanuel County Hospital for 1980. **Chang Kue Kim, M.D.,** also of Swainsboro, was elected secretary-treasurer. MAG members who were appointed as medical chiefs of service include: **Robert J. Moye, M.D.,** anesthesia; **James L. Ray, M.D.,** respiratorial therapy and medicine; **H. Wilder Smith, M.D.,** obstetrics; **William Mullins, M.D.,** pathology; **Dr. Frost,** laboratory; **Dr. Kim,** radiology; and **Carter L. Meadows, M.D.,** surgery.

The Press-Sentinel of Savannah honored **Thomas Yeh, M.D.,** in an article on a recent coronary bypass operation which he performed.

Second District

Charles Bellville, M.D., after 30 years of practicing in Bainbridge, has retired.

William A. Thompson, M.D., Thomasville, has been named a diplomate of the American College of Obstetrics and Gynecology.

Fourth District

Robert M. Fine, M.D., of Decatur, was recently certified as a Diplomate of the American Board of Allergy and Immunology, a conjoint board of the American Board of Internal Medicine and the American Board of Pediatrics.

Fifth District

James S. Cheatham, M.D., has recently joined the Psychiatric Institute of Atlanta as staff psychiatrist. Prior to assuming this position, he was in private practice in Chattanooga, Tennessee, and Dalton, Georgia.

Atlanta surgeon **Charles Hatcher, M.D.,** spoke to Heart Association volunteers at the 1980 Decatur County Heart Fund Kickoff Banquet on February 1.

Homer Nash, M.D., one of Atlanta's oldest physicians, recently received special Atlanta Medical Association award. Dr. Nash is also a member of the Medical Association of Atlanta.

Sixth District

Norman J. Smith, M.D., has opened an office in Macon at the Coliseum Park Hospital Professional Building.

Seventh District

Robert J. Alpern, M.D., Smyrna, was recently named a Fellow of the American Academy of Child Psychiatry.

Stanley Fineman, M.D., Marietta, is a new diplomate of the American Board of Allergy and Clinical Immunology, a conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics.

Phillip H. Kaleida, M.D., Dalton, was certified as a Diplomate of the American Board of Pediatrics.

Henry D. Meaders, M.D., a Marietta gynecologist, was named Cobb County's "Citizen of the Year" during the Chamber of Commerce 38th annual dinner and meeting held January 25 at the Atlanta Marriott Hotel.

Ronald Roper, M.D., Marietta, was awarded the "Silver Beaver Award" by the Atlanta Area Council, Boy Scouts of America. This is the highest award a Council can give.

Don Schmidt, M.D., Cedartown, recently re-entered the U.S. Navy to serve as a lieutenant commander. The Cedartown City Commission honored him by proclaiming February 21, 1980, as Dr. Don Schmidt Day.

Dan B. Stephens, M.D., Marietta, was elected to membership in the Southern Gynecological and Obstetrical Society.

Luis M. Viamonte, M.D., Dalton, was recently certified as a Diplomate of the American Board of Pediatrics.

Ninth District

Radiologist **Robert Miles, M.D.,** of Elberton, has joined the Elberton-Elbert County medical staff.

Tenth District

William L. Clark Jr., M.D., has been elected president of the medical staff of University Hospital in Augusta.

SOCIETIES

G. Douglas Talbott, M.D., Director of MAG's Disabled Doctors program, spoke to the **Carroll-Haralson Medical Society and Auxiliary** on February 18. His subject was the Disabled Doctors Program.

At their March meeting the **Cobb County Medical Society** were guests of the Lockheed Corporation in Marietta. The evening included a dinner, a short film of Lockheed products, and a tour of the plant.

Drs. Harrison L. Rogers, James Kaufmann, and Mr. Rusty Kidd were guests at the Legislative Dinner hosted by the **Muscogee County Medical Society** (CMS) and Auxiliary for the local legislators. Dr. Rogers presented the speech for the evening. The Muscogee CMS celebrated Doctors' Day, March 30, with a dinner dance at the Big Eddy Club. The Society will also host the **Third District Medical Society** meeting in Columbus on April 10, 1980, at the Convention and Trade Center.

Mrs. Michael Glucksman, president of the Auxiliary to the Medical Association of Georgia, addressed the **Sumter County Medical Society Auxiliary** on January 24.

DEATHS

Charles Edward Rushin

Charles E. Rushin, M.D., 88, died at Crawford W. Long Memorial Hospital on Sunday, January 27.

Dr. Rushin was born in Boston, Georgia, and moved to Cairo in 1904. After receiving his M.D. degree, he moved to Atlanta where he practiced for nearly 60 years.

Survivors include two grandchildren and a sister-in-law. The family requests that memorial contributions be made to the American Cancer Society.

Ellis H. Dixon Jr.

Ellis H. Dixon Jr., M.D., died Friday, February 1.

A native of Athens, Dr. Dixon was a graduate of the University of Georgia and the Medical College of Georgia where he was a member of Theta Kappa Psi medical fraternity. Prior to beginning his medical practice in Athens in 1956, Dr. Dixon served a rotating internship and residency in obstetrics and gynecology at University Hospital in Augusta. He was on the faculty of the Medical College of Georgia for 1 year and served two tours of duty in the U.S. Army Medical Corps.

Dr. Dixon was on staff of Athens General Hospital and St. Mary's Hospital. He was formerly the chief of obstetrics and gynecology and president of the medical staff at Athens General Hospital.

A past president of the Clarke County Medical Society, Dr. Dixon was also a member of the Medical Association of Georgia, the American Medical Association, the Georgia State Obstetrics and Gynecology Society and was a Fellow and a Diplomate of the American College of Obstetrics and Gynecologists.

Survivors include his wife, two daughters, one son, his mother, a sister, and three grandchildren.

Randall Gay Brown

Randall G. Brown, M.D., 72, died Tuesday, February 12, at his residence.

Dr. Brown was a native of Emanuel County. He was a retired medical doctor, a member of First Baptist Church, a veteran of World War II, and a member of the Kiwanis Club for 40 years. Professionally, he had been a Fellow in the Southeast Surgical Congress, a member of the Emanuel County Medical Association, past president of the Medical District Association, a member of the Medical Association of Georgia, the American Medical Association, the Southern Medical Association and the V.F.W., and a lifetime member of the National Rehabilitation Association.

Survivors include his wife, one son, and one daughter.

Memorials may be made to the American Cancer Society.

Keogh— to prepare for the years ahead.

Keogh at Fulton Federal is a retirement plan for the self-employed. It allows you to contribute 15% of your earned income, up to $7500 per year, and defer taxes on your deposits, until you retire.

If you already have a Keogh Account, please note that contributions can be made as late as the tax filing deadline, including extensions.

To find out more, call Fulton Federal's Retirement Plan Counselors at (404) 586-7031. Keogh— it's the way to prepare for the years ahead, starting today.

EQUAL HOUSING LENDER

Fulton Federal Savings

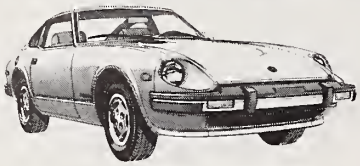
Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 Atlanta, Georgia 30301 404-586-7283


Have a Coke®
and a smile.
Coke® adds life.
registered trade-marks which identify the same product of The Coca-Cola Company.

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Specialized Health Care in the Heart of Atlanta



Adult Inpatient Treatment
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

Psychiatric Institute of Atlanta • 811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151



V-Cillin K®
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

***Equivalent to penicillin V.**

Additional information available to the profession on request.

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

900416

TALK IS CHEAP

in the *Journal*'s Classifieds

Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The ***Journal*'s Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.

For Physicians Only:

6-MONTH TERM LOANS UP TO $15,000

EXAMPLES:

AMOUNT FINANCED	FINANCE CHARGE	TOTAL OF PAYMENTS
$5,000.00	$ 450.00	$5,450.00
10,000.00	900.00	10,900.00
15,000.00	1,350.00	16,350.00

ANNUAL PERCENTAGE RATE: 18%
(Credit Life Insurance also available.)

We make confidential, unsecured loans on the strength of your signature by mail. Longer term repayment loans also available at competitive rates. **Deal direct — No broker fees.** Contact us today.

For complete information call toll-free: 1-800-238-5594 or collect: 901-767-8060 . . . or return this coupon.

SFC Financial Services
Mr. Charles M. Mathis, Jr
Executive Loan Director
10921 E. 41st Street
Tulsa, Oklahoma 74145

Please send confidential loan application to:

Name _____

Address _____

City _____ State _____ Zip _____

(Not applicable to residents of AR, CA, NC, OR & WA)

The Great CHEROKEE TRADING COMPANY®

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

COMPLETE VIDEO-TAPE SERVICES FOR THE MEDICAL PROFESSIONAL



Operation documentation
Patient information programs
Video duplication
Training tapes
Equipment consultation and design
Program design and consultation
Documentation of new techniques

ATLANTA VIDEO SERVICE
161 SPRING ST., NW
ATLANTA, GA. 30303
404 522-9068

Classifieds

PHYSICIANS WANTED

Emergency Department Physician Wanted Immediately. Full-time position open in Savannah, GA. Excellent working conditions, and excellent remuneration. Call (912) 925-3610 and leave a message, or write Box 4-A, c/o the *Journal,* 938 Peachtree St., NE, Atlanta, GA 30309.

Wanted — Volunteer physicians, long and short term, in Bolivia, Cameroons, Chile, Colombia, Costa Rica, Dominican Republic, Educador, Ghana, Guatemala, Guyana, Haiti, Honduras, Ivory Coast, Lesotho, Liberia, Paraguay, Peru, Sierra Leone, Tanzania, Uruguay, and West Indies. Contact: Catholic Medical Mission Board, Placement Director, 10 W. 17th St., New York, NY 10011.

Full-time Assistant Professor, Division of Cardiology, Department of Medicine, Emory University School of Medicine. Candidate should be qualified to take the American Board Exam in Internal Medicine and the subspecialty examination in Cardiovascular Diseases with at least three years of formal training in cardiovascular diseases in an approved program in the United States. Candidate should be fully qualified to perform cardiac catheterization and coronary arteriography without supervision, to perform and interpret radionuclide myocardial imaging, and to perform and interpret echocardiograms, electrocardiograms, and phonocardiograms. In addition, candidate should have extensive experience in the medical management of patients prior to and following cardiac surgery and the management of patients in a coronary care unit. Experience teaching medical students and residents is required as well as a proven research record. Candidate should be available for extensive work during nights and weekends, and must be available to assume duties June 1, 1980. Salary $40,000. Contact: Dr. Robert Schlant, Dept. of Medicine, Emory University School of Medicine, 69 Butler St., SE, Atlanta, GA 30303. (Job #609457) An Equal Opportunity/Affirmative Action Employer.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call 634-1234.

SERVICES

Listings needed for apartments, motels, and pine timberland. Investment Services Company-Realty, 1100 Spring St., Atlanta, GA. Contact: Jere Housworth, 4276 Durham Cir., Stone Mountain, GA 30083. PH: (404) 294-6594.

DECATUR NORTH PROFESSIONAL BUILDING



- ADJACENT TO DECATUR HOSPITAL IN HEART OF DECATUR
- WITHIN TWO MILES OF DeKALB GENERAL VETERANS ADMINISTRATION AND EMORY UNIVERSITY HOSPITALS
- TWO BLOCKS FROM DECATUR MARTA RAPID TRANSIT STATION
- NINE STORIES WITH 87,000 SQUARE FEET
- ON-SITE OWNER MANAGEMENT
- COVERED PARKING FOR TENANTS
- TWO HOURS' FREE PARKING FOR PATIENTS
- ON-PREMISES PHARMACY, RADIOLOGICAL DEPARTMENT, LABORATORY, MEDICAL SUPPLIES, OPTICAL SHOP, BARBER SHOP AND SANDWICH SHOP

The Decatur North Professional Building, specializing in space for professional practices, is located in the Heart of Decatur and close to four major hospitals. Within easy access to bus and rail transportation, Decatur North Professional Building is quickly accessible to Atlanta and other points in metropolitan Atlanta.

CALL:
MARTIN D. TAFFEL, PROPERTY MANAGER
Decatur North Professional Building
755 Columbia Drive, Decatur, Georgia 30030
Leasing Information 404/377-9984 or 586-1165

Index to Advertising

Vol. 69 APRIL 1980 No. 4

American Medical Association 272
Arthritis Foundation 316
Atlanta Video Service 326
Ballard, Walter, Optical Company 253
Blackbeard Yachts Ltd. 253
Boehringer Ingelheim Ltd. 310-312
Brawner Psychiatric Institute 280
Burroughs Wellcome Company 269
Classifieds 327
Coca-Cola Company 323
Decatur Hearing Aid Service 299
Decatur North Professional Building 327
The Devereux Foundation 305
Dickey-Mangham Company 324
Fenwick Hall 268
Fulton Federal Savings and Loan Association 322
Georgia National Guard 300
Global Imports 283
The Great Cherokee Trading Company 326
Hickman-Datsun 324
Insurance Corporation of America 260, 261
Janssen Pharmaceuticals 298, 299
JMAG Classifieds 326
Lilly, Eli, and Company, ... 325
Medicard 263
The Morrill House 283
Office Communications, Inc. 288
Ortega Pharmaceutical Company, Inc. 304
Peachtree and Parkwood Mental Health Center and Hospitals 287
Pharmacia Laboratories 308
Potter-Holden and Company 299
Psychiatric Institute of Atlanta 324
Recording for the Blind, Inc. 316
Roche Laboratories 252, 253, 329, 330
The Rocker Shop 259
Rorer, William H., Inc. 270-272
SFC Financial Services 326
Smith, Kline, & French 309
Valley Psychiatric Hospital 259
Weight Watchers of Greater Atlanta 304
Willingway Hospital 286
Wyeth Laboratories 289-292

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

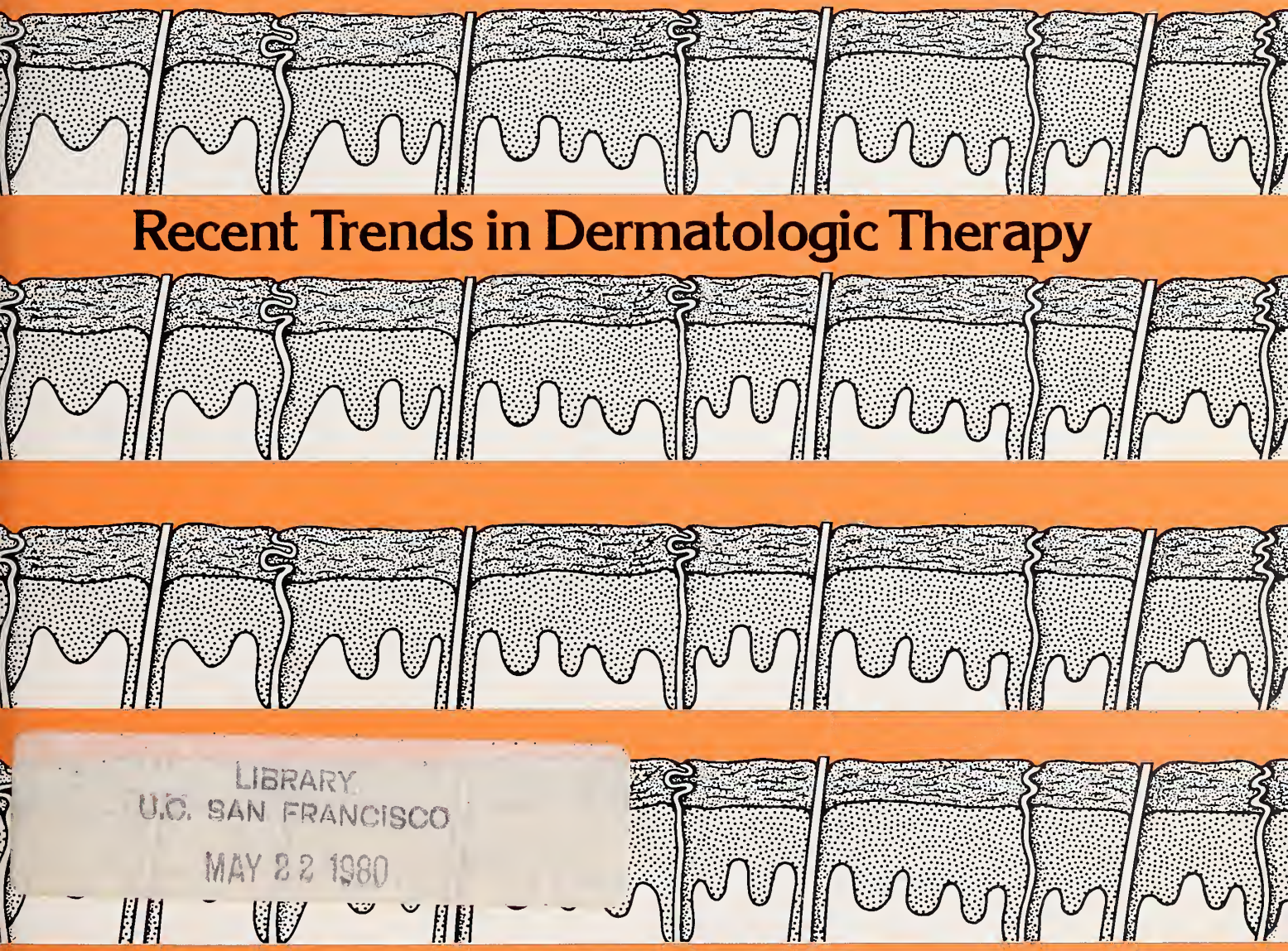
ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

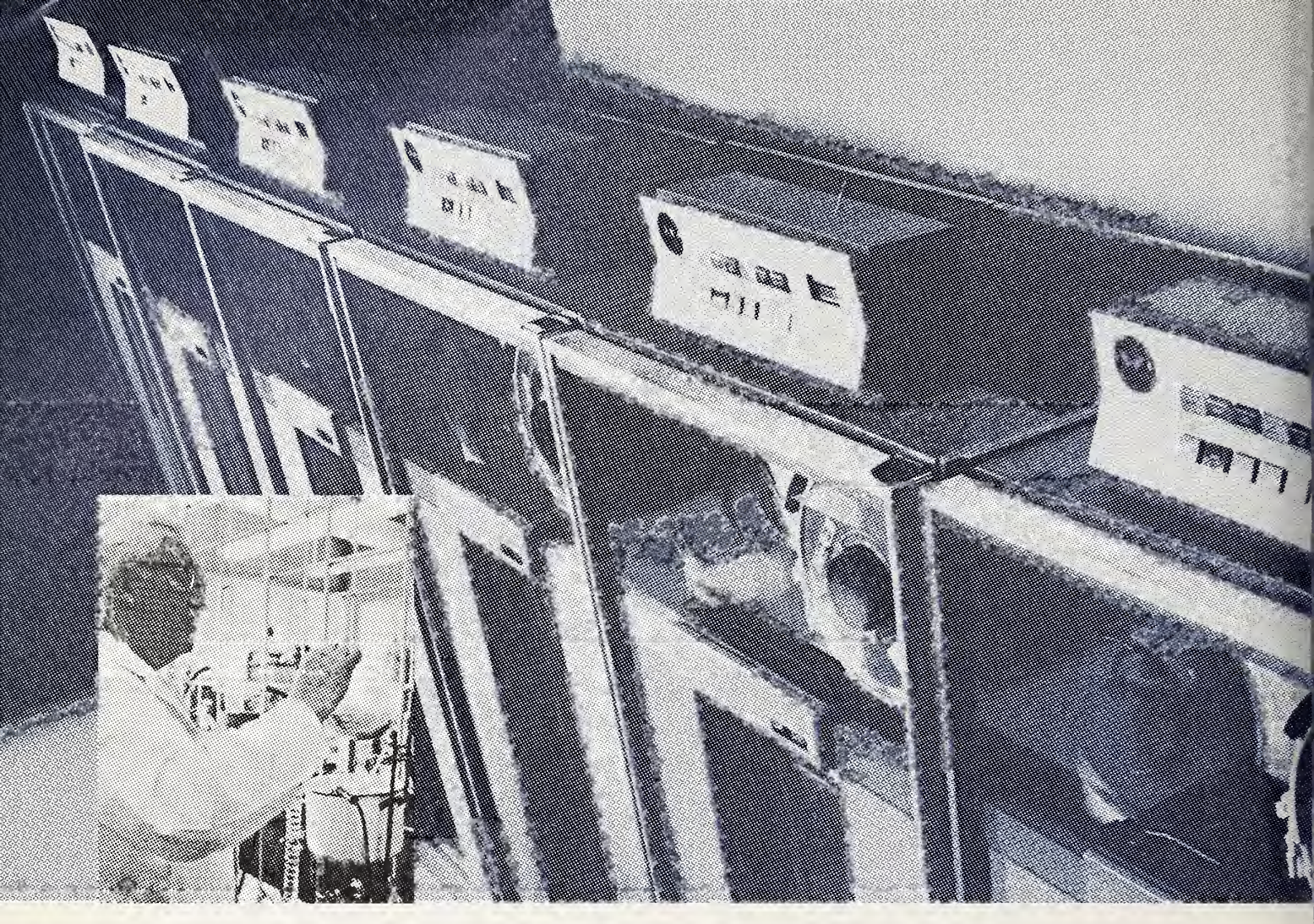
MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

JOURNAL
of the medical association of
georgia
ISSN·0025·7028 MAY / 1980



Recent Trends in Dermatologic Therapy

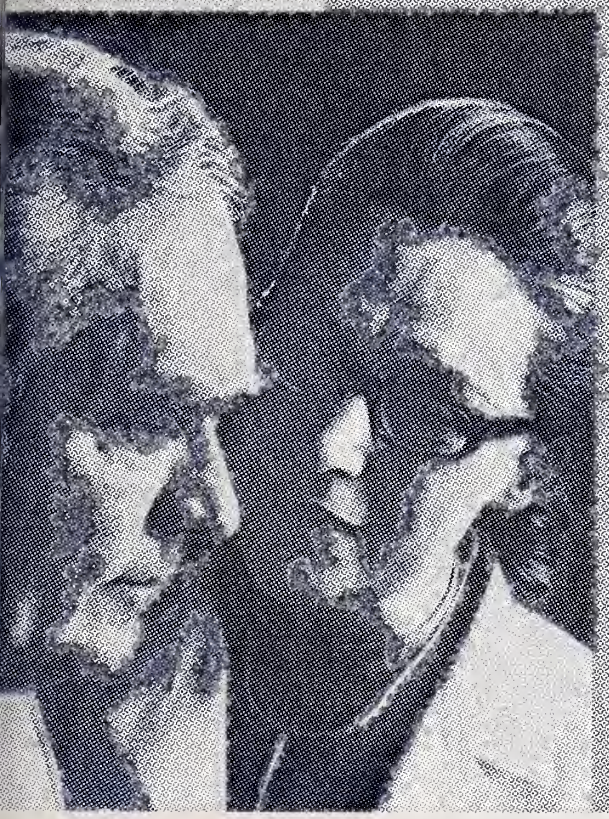
LIBRARY
U.C. SAN FRANCISCO
MAY 22 1980



proven antianxiety

Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). **And today this promise continues to be fulfilled in a wide variety of patients you see every day.**

ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® Ⓜ
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- An unsurpassed safety record
- Minimal effect on mental acuity, in proper dosage
- Predictable patient response
- Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

Are you paying taxes on your savings interest again this year?

If so, you need to learn about Fulton Federal's Tax Deferrer. It's a savings plan that lets you defer taxes on your interest until you are in a lower tax bracket. With a minimum deposit of $5,000, your funds will be invested in the highest yield for which your account qualifies.* (There's a small annual service fee, as well as a one-time processing fee.) For more information, call or come by the Fulton Federal branch nearest you.

*A substantial interest penalty is required for early withdrawal.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 • Atlanta, Georgia 30301 • 404-586-7283

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 5

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director and Director of Legislative Activities
Stephen L. Daniel, Ph.D., Assistant Executive Director — Education
J. Tom Sawyer, Assistant Executive Director — Administration
Kenneth M. Williams, Director of Public and Professional Relations
Joyce Butler, R.N., Director of Medical Practice
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

345 Current Trends in Dermatology
Donald J. Pirozzi, M.D.
355 L-Asparaginase and Toxic Epidermal Necrolysis
Antonio R. Rodriguez, M.D.
359 Calculi in a Non-Functioning Kidney
Letitia Clark, M.D.
Roy M. Waller III, M.D.
Ayten Someren, M.D.
371 *Clinical Note:* Brucellosis
G. Andrew Sendelbach, B.S.
Kenneth Alonson, M.D., F.A.C.P.
Raymundo Mallari, M.D.
G. R. Foster Jr., M.D.

SPECIAL ARTICLES

367 A Third-Party Perspective on Health Care Costs
Fred R. Higginbotham
377 Computerized Literature Search in the Community Hospital
Cynthia N. Timm, M.L.S.
Mark E. Silverman, M.D.
Nicholas E. Davies, M.D.
385 Report of Some of the Effects of Georgia's New Civil Commitment Law on Patients in a Private Psychiatric Hospital
Dave M. Davis, M.D.

EDITORIAL

379 The Paradox of Pharmaceutical Advertising
Edgar Woody Jr., M.D.

FEATURES

387 Legal Page/What to Do and Not Do In the Emergency Treatment of Mentally Ill Persons
Robert N. Berg
395 Heart Page/Potassium-Rich Foods — Do They Do the Hypertensive Patient Any Good?
S. Heyden, M.D.
C. G. Hames, M.D.
I. Talton, M.D.
399 Cancer Page/Evaluation of the Abnormal PAP Smear — Colposcopy or Conization?
John L. Powell, M.D.

THE ASSOCIATION

391 Physician's Recognition Award Recipients
404 President's Letter/My View of Leadership
H. Hilt Hammett, Jr., M.D.
405 New Members
406 Personals
406 Societies
406 Deaths

INCIDENTAL INTELLIGENCE

336 Federal Trade Commission Broadens Its Front in Attack on Medicine
336 Daily Prayer of Maimonides
337 Georgia Physician Receives Top Award in High Blood Pressure Control
337 Quit Smoking Tips From the American Cancer Society
338 Rehabilitation in Georgia
340 Medical Meeting Calendar

THE COVER

Cover illustration by Charles Boyter from the medical illustrations department at Emory University School of Medicine. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

Federal Trade Commission Broadens Its Front in Attack on Medicine

To what degree will the Federal Trade Commission (FTC) be able to encroach on our medical professionalism and the public-spirited responsibilities that go with it?

This question loomed when the FTC challenged the AMA's ethical ban on physician solicitation of patients. It also is looming again on the issue of the FTC and medical-school accreditation, an issue that had been in abeyance during a 2-year grace period.

The advisory committee to the U.S. Commissioner of Education was scheduled to open a hearing April 21 on the FTC's petition to dislodge the Liaison Committee on Medical Education (LCME) as the accrediting body for medical schools.

As cosponsor of the LCME — along with the Association of American Medical Colleges (AAMC) — the AMA is again the prime target of the FTC action, just as in the ongoing case on physician advertising and solicitation.

FTC lawyers exultantly smell a rat in the AMA's accreditation role. They contend the Association wants to limit the number of schools and graduates for the same basic reason it allegedly wants to limit the scope of advertising: to stifle intraprofessional competition.

The contention is out of touch with the facts, of course. Instead of being held down, **the number of approved medical schools has surged (with full AMA support) from 85 in 1960 to 126 today. Enrollment in that time has more than doubled.**

Well, the FTC counters, the LCME just might sometime restrict the school growth.

Another federal agency — HEW — foresees no restriction. In a recent report, HEW stated: "Our nation's schools are currently geared to produce doctors at a rate that should put the total number in balance with our national needs by the 1980s. By the 1990s, we should have a supply greater than we will need."

In its move on accreditation, the FTC is joined by such "public interest" groups as Common Cause and Sidney Wolfe's Public Citizen Health Research Group. We feel it is clearly in the public interest for the AMA to continue to wage arduous if costly battles to keep medical professionalism intact.

(Prepared by the AMA Office of Public Relations.)

Daily Prayer of Maimonides

Maimonides, who lived from 1135 to 1204, was a noted Jewish rabbi philosopher. His primary philosophical work, *The Guide of the Perplexed,* was completed in 1190 and attempted to harmonize Judaism with the teachings of Aristotle. It influenced such Christian theologians as St. Thomas Aquinas. Because of persistent persecution, he was forced to leave his home in Córdoba, Spain, in 1148, and after much peripatetic wanderings finally settled in Egypt. He wrote a variety of works on medicine, law, logic, and astronomy.

Almighty God, You have created the human body with infinite wisdom. In Your Eternal Providence You have chosen me to watch over the life and health of your creatures. I am now about to apply myself to the duties of my profession. Support me in these great labors that they may benefit mankind for without Your help not even the least thing will succeed.

Inspire me with love for my art and for Your creatures. Do not allow thirst for profit, ambition for renown and admiration to interfere with my profession. For these are the enemies of truth and can lead me astray in the great task of attending to the welfare of Your creatures. Preserve the strength of my body and soul that they may be ever ready to help rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being.

Enlighten my mind that it may recognize what presents itself and that it may comprehend what is absent or hidden. Let it not fail to see what is visible but do not permit it to arrogate to itself the power to see what cannot be seen for delicate and indefinite are the bounds of the great art of caring for the lives and health of Your creatures. May no strange thoughts divert my attention at the bedside of the sick or disturb my mind in its silent labors.

Grant that my patients may have confidence in me and my art and follow my directions and my counsel. When those who are wiser than I wish to instruct me, let my soul gratefully follow their guidance for vast is the extent of our art. Imbue my soul with gentleness and calmness. Let me be contented in everything except in the great science of my profession. Never allow the thought to arise in me that I have attained to sufficient knowledge but vouchsafe to give me the strength and the ambition to extend my knowledge. The art is great, but the mind of man is ever expanding.

Almighty God You have chosen me in Your mercy to watch over the life and death of Your creatures. Support me in Your great tasks so that it will benefit mankind, for without Your help not even the least thing will succeed.

(Reprinted from the February, 1980, issue of the Bulletin of the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn, Inc.)

Georgia Physician Receives Top Award in High Blood Pressure Control

Joseph A. Wilber, M.D., of Atlanta has received the first National Award for High Blood Pressure Control. The award was presented by the National Conference on High Blood Pressure Control at its annual meeting in Houston, Texas.



Dr. Wilber

He was honored for his research in community high blood pressure programs, which has resulted in increased awareness and treatment of high blood pressure in Georgia and for his role in the recognition of high blood pressure as a major national health problem. "His early efforts included comparison of screening methods and the use of nurses and other health professionals to monitor and control high blood pressure," the award citation stated.

Dr. Wilber initiated the first public health program in the nation in high blood pressure detection and control in Baldwin County, Georgia, in 1962. This demonstration study led to a state and federally funded Stroke and Heart Attack Prevention Program in 115 counties in Georgia. The screening programs he started are being carried out in health departments in all 159 counties and are used as models for programs in other states.

Dr. Wilber is medical consultant to the Georgia Department of Human Resources and medical director of Georgia International Life Insurance Company. He is pas president of the Georgia Affiliate of the American Heart Association. He is principal investigator for FOCUS, a 5-year research project funded by the National Heart, Lung, and Blood Institute to study whether coordination of private, public, and voluntary health agencies and related non-medical groups such as commerce, industry, and government will result in improved high blood pressure control.

Quit-Smoking Tips From the American Cancer Society

1. Before you quit smoking, try wrapping your cigarettes with a sheet of paper like a Christmas present. Every time you want a cigarette, unwrap the pack and write down what you are doing, how you feel and how important this cigarette is to you. Do this for two weeks and you'll have cut down as well as developed new insights into your smoking.
2. Make a list of what you like and dislike about smoking. Add to it and read it daily.
3. List the luxuries you have wanted or items you would like to purchase for a loved one. Next to each item write the cost. Then convert the cost to "packs of cigarettes." If you save the money each day from packs of cigarettes you would have bought, you will be able to purchase these items. Use a special "piggy" bank for saving your money, or start a "Christmas Club" account at your bank.
4. Bet someone that you can quit. Put cigarette money in a jar each morning and forfeit it if you smoke. You keep the money if you don't smoke by the end of the week. Try to extend this period to a month.
5. Plan a *date for stopping*. You might choose your vacation, New Year's Day, your birthday, a holiday, the birthday of your child, your anniversary. But, don't make the date so distant that you lose momentum.
6. If you smoke under stress at work, pick a date for stopping when you will be away from work.
7. Decide whether you are going to stop suddenly or gradually. If it is to be gradual, work out a tapering system so that you have intermediate goals on your way to an "I.Q." day.
8. Until you quit, make yourself a "smoking corner" far from anything interesting. If you like to smoke with others, always smoke alone. If you like to smoke alone, always smoke with others, preferably if they are non-smokers. Never smoke while watching television.
9. Change your brand of cigarettes weekly so you are smoking a brand lower in tar and nicotine than the week before.
10. Keep your hands occupied. Try playing a musical instrument, knitting or working with hand puzzles.
11. Take a shower. It's hard to smoke in the shower.
12. Brush your teeth frequently to get rid of tobacco taste and stains.
13. If you have a sudden craving for a cigarette, take ten deep breaths, holding the last breath while you strike a match. Exhale slowly, blowing out the match. Pretend the match was a cigarette by crushing it out in an ashtray. Then immediately get busy on some work or activity.
14. Smoke only one-half a cigarette.
15. Shed your old habits. Seek new activities or perform old activities in new ways. Don't rely on the old ways of solving problems. Do things differently.
16. Visit places where you can't smoke such as libraries, buses, theaters, swimming pools, department stores.

QUICK-QUIT PLAN

1. List the reasons for and against smoking.
2. Change to a low tar, low nicotine brand.
3. Select a day to quit.
4. Chart your smoking habits for two weeks: how

many cigarettes, when, which is the most and least important.
5. Each night, repeat at least ten times one of your reasons for not smoking.
6. Eliminate one cigarette from your routine: the most or least desired.
7. Quit on the day you selected. Keep busy: go to the movies, exercise, take long walks. Use substitutes, sip water, chew gum, eat raisins or carrots, chew a clove.

American Cancer Society, Inc.

Rehabilitation in Georgia

In 1972, the national commission made a number of recommendations to the states referrable to changes in workers' compensation laws. High on the list was a suggestion that each state have a rehabilitation program to restore injured workers to their maximum physical function and to suitable employment. In 1975, the Georgia Workers' Compensation Act was amended to include rehabilitation services as a benefit in addition to weekly compensation and medical care. These benefits are monitored and regulated by the Workers' Compensation Board.

Unlike most states, Georgia's rehabilitation act is mandatory. This mandatory rehabilitation act provides that the employer/insured must assess the rehabilitation needs of each injured worker who is off the job as long as 105 days and report to the Workers' Compensation Board. Should rehabilitation services be indicated, the employer/insured must assign the case to an approved rehabilitation supplier. This supplier may be a rehabilitation nurse or rehabilitation counselor from an insurance carrier, the State Division of Vocational Rehabilitation, or a private vendor. This supplier is responsible for gathering information and preparing an appropriate plan for rehabilitation services. The employer/insurer's failure to furnish necessary rehabilitation services can result in a penalty up to $1,000.00.

In recent months, much criticism has been voiced by physicians throughout the state regarding rehabilitation nurses and/or suppliers. In a number of instances, rehabilitation nurses have insisted on being present within the doctor's office or even within the examining room. There have been episodes in which the rehabilitation nurse has "threatened" a physician as regards his payment for treatment if he did not accept her suggestions. Instances are reported where the rehabilitation nurse has changed the patient from one physician to another. Unfortunately, there have also been an equal number of complaints from rehabilitation nurses that physicians have refused to submit information or assist in formation of a suitable rehabilitation plan.

Ms. Lynda Snyder heads the Department of Rehabilitation Services and works within the jurisdiction of the Workers' Compensation Board. Judge Charles Booker is responsible for legal aspects referrable to a rehabilitation program. All rehabilitation plans are submitted to Ms. Snyder for approval and interested parties have 10 days in which to file any objections. Unfortunately, many physicians have patients who have such plans submitted, and the physician may be totally unaware of such activities. I have been assured by Ms. Snyder that notification of such plans will be sent to the treating physician in the future. The Workers' Compensation Board is aware that many suppliers have personnel which may lack adequate training or appropriate experience. In an effort to upgrade the system, an advisory committee has been formed for the rehabilitation unit. This advisory committee is composed of physicians, attorneys, and rehabilitation suppliers. If a physician has a legitimate complaint against a rehabilitation nurse or supplier, a letter should be sent to Dr. Thomas Marks, Ad Hoc Committee on Rehabilitation-Workers' Compensation, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta, GA 30309. A copy should also be sent to Judge Charles Booker, State Board of Workers' Compensation, 1800 Peachtree St., NW, 4th Floor, Atlanta, GA 30309. The Rehabilitation Advisory Committee has the authority to review such complaints and, if warranted, a nurse or supplier may have certification removed. If a physician has such a complaint, the name of the patient and the name of the rehabilitation nurse and/or counselor must be included.

In an effort to improve understanding between the physician and the rehabilitation suppliers, a seminar is to be held in Atlanta on June 10, 1980, at the Sheraton-Atlanta Hotel, 590 W. Peachtree St., NW, Atlanta, GA 30308. At this time, the physician will be given an opportunity to discuss problems with the Compensation Board and the Department of Rehabilitation. The rehabilitation nurses will also be given the chance to voice their complaints about physicians' cooperation. It is hoped that interested physicians will take advantage of this opportunity to express constructive criticism. Requests for information regarding registration should be mailed to Ms. Lynda Snyder, Director of Rehabilitation, State Board of Workers' Compensation, 1800 Peachtree St., NW, 4th Floor, Atlanta, GA 30309. (Reported by Tom Howell, M.D.)

"Thank you, doctors, for your referrals."



Many doctors refer their obese patients to us.

We call our weight-loss program "natural weight loss". The reason: Our nurse-supervised program employs no medication—neither oral or injectible. Our program uses neither liquid nor powdered protein—no pre-cooked foods—no aversion therapy. Instead, we provide a program of sound nutrition. The right foods. Nutritionally-correct groupings. Reduced caloric intake.

At CLINICAL WEIGHT LOSS, our caring professional staff and registered nurses provide personal counseling as well as nutritional guidance.

We would be happy to send you complete information on our natural weight-loss program for your review. And the names of physicians who have referred obese patients to us.

Have your nurse call us today.

We do what you'd do if you had the time.

Clinical Weight Loss

"Where you can have confidence in our reputation"

Peachtree	Cumberland	Northlake	Sandy Springs	College Park
2964 Peachtree Rd.	2814 New Spring Rd.	2256 Northlake Pkwy.	5801 P'tree Dunwoody Rd.	1571 Phoenix Blvd.
233-0641	**435-6148**	**939-5577**	**252-7016**	**996-2564**

MEDICAL MEETING CALENDAR

MAY

22-23—*Chattanooga, TN;* **ENDOCRINE DIAGNOSIS AND THERAPY FOR THE PRIMARY CARE PHYSICIAN;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis TN 38163. PH: 901/528-5605.

22-24—*Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

23-24—*Atlanta;* **NUTRITION & CANCER INTERRELATIONSHIPS;** Contact: Corinne Cataldo, Emory Univ. Sch. of Med., 2040 Ridgewood Dr. NE, Atlanta 30322. PH: 404/329-6130.

24—*Chattanooga, TN;* **NEW CONCEPTS IN DIAGNOSIS: MANAGEMENT OF DIABETES;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

30-31—*Birmingham, AL;* **RHEUMATOLOGY, NEUROLOGY, GASTROENTEROLOGY, DERMATOLOGY;** Contact: Jaan Kangilaski, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

JUNE

5-7—*Atlanta;* **EIGHTH ANNUAL HAND SYMPOSIUM: REHABILITATION FOLLOWING TENDON INJURIES;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

5-8—*Chattanooga, TN;* **FAMILY MEDICINE REVIEW;** Contact: Dennis K. Wentz, M.D., Univ. of Tenn. Ctr. for the Health Sciences, 800 Madison Ave., Memphis, TN 38163. PH: 901/528-5605.

12-13—*Orlando, FL;* **STROKE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

12-14—*Jekyll Island;* **SELECTED TOPICS IN INTERNAL MEDICINE;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

13-15—*Pinehurst, NC;* **EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646 (toll free).

18-21—*Atlanta;* **JOINT MEETING GEORGIA PUBLIC HEALTH ASSOCIATION AND THE SOUTHERN BRANCH AMERICAN PUBLIC HEALTH ASSOCIATION;** Contact: Thomas McKinley, President, GPHA, P.O. Box 38183, Atlanta 30034. PH: 404/656-4764.

23-27—*Lake Buena Vista, FL;* **MKSAP-V (INTERNAL MEDICINE REVIEW, ACP);** Category 1 credit; Contact: Bill Rockwood, Coordinator, Box J-233, J. Hillis Miller Health Ctr., Office of CME, Gainesville, FL 32610. PH: 904/392-3143 or 392-3183.

26-28—*Hilton Head Island, SC;* **AMERICAN COLLEGE OF CHEST PHYSICIANS: CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND ASTHMA;** Category 1 credit; Contact: Thomas L. Petty, M.D., Chairman, Postgraduate Med. Educ. Committee, ACCP, P. O. Box 93826, Chicago, IL 60670. PH: 312/698-2220.

JULY

11-13—*Orlando, FL;* **CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646 (toll free).

19-25—*Atlanta;* **AMERICAN COLLEGE OF PHYSICIANS MKSAP-V COURSE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

21-25—*Atlanta;* **MKSAP: ALLERGY/IMMUNOLOGY, INFECTIOUS DISEASES, ENDOCRINOLOGY/METABOLISM, ONCOLOGY, HEMATOLOGY, CARDIOVASCULAR DISEASES, PULMONARY DISEASES, NEPHROLOGY, RHEUMATOLOGY, NEUROLOGY, GASTROENTEROLOGY, DERMATOLOGY;** Contact: Jaan Kangilaski, ACP, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

22-26—*Hilton Head Island, SC;* **CONTEMPORARY CLINICAL NEUROLOGY;** Category 1 credit; Contact: Vanderbilt Univ. CME, 3200 West End, Suite 306, Nashville, TN 37203. PH: 615/322-2716.

27-30—*Hilton Head Island, SC;* **THIRD ANNUAL SYMPOSIUM: NUCLEAR CARDIOLOGY FOR THE PRACTICING PHYSICIAN;** Category 1 credit; Contact: J. S. Soin, M.D., Div. of Nuclear Medicine, Milwaukee County Medical Complex, 8700 West Wisconsin Ave., Milwaukee, WI 53226. PH: 414/257-5968.

28-30—*Kiawah Island, SC;* **PEDIATRICS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Div. of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

AUGUST

4-8—*Atlanta;* **TAX, RETIREMENT, AND ESTATE PLANNING AND FINANCIAL INVESTMENTS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Div. of Continuing Education, MCG, Augusta 30912. PH: 404/828-3967.

11-15—*Atlanta;* **INTERNAL MEDICINE BOARD REVIEW;** Category 1 credit; Contact: Daniel M. Smaw, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3525.

11-15—*Atlanta;* **RECENT ADVANCES IN INTERNAL MEDICINE;** Category 1 credit; Contact: Daniel M. Smaw, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3525.

17-22—*Atlanta;* **RECENT ADVANCES IN INTERNAL MEDICINE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St. SE, Atlanta 30303. PH: 404/588-3534.

21-22—*Birmingham, AL;* **SEMINAR ON QUALITY ASSURANCE;** Category 1 credit; Contact: Jim Hulett, Alabama Hospital Assn., Box 17059, East Station, Montgomery, AL 36117. PH: 205/272-8781.

22-24—*Hilton Head Island, SC;* **CLINICAL MANAGEMENT OF CORONARY DISEASE AND EXERCISE TESTING;** Category 1 credit; Contact: Dir. of CME, Dept. 4, International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646, Ext. 236 (toll free).

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

OVER

55

FREE DINNERS



Symbol of Excellence

ONLY

$~~20~~

A SEASON

The Carriage Trade Dinner Club®

ATLANTA'S 14th SENSATIONAL PROGRAM

Restaurants Participating • June 1, 1980 thru November 30, 1980

AMBASSADOR Atlanta
GRANARY Smyrna
COGNITO'S Atlanta
SPENCER'S Atlanta
GREGORY'S Atlanta
O'HENRY'S Atlanta
e.j.'s Atlanta
RONI & DEE Atlanta
HOBNOBS (Atlanta Biltmore) Atlanta
MARIO'S OF DUNWOODY Dunwoody
TYRONE'S Atlanta
TORE'S ITALIAN VILLA Atlanta
PETITE AUBERGE Atlanta
CIRO'S Atlanta
BAMBOO GARDEN Gainesville
S.P. GETTI & AMIGOS Marietta
DUDLEY'S College Park/Decatur
AUSTIN RESTAURANT Atlanta
LITTLE GARDENS Lawrenceville
TOWER RIB ROOM Atlanta
COLORADO MINING COMPANY Atlanta
TOP OF THE MART Atlanta
ICHIBAN STEAK HOUSE Atlanta
HARRISON'S ON PEACHTREE Atlanta
BARN DINNER THEATER Marietta
CASHIN'S PLACE Marietta
CHINA PALACE Marietta
THE TANNERY Buford
ANGELO'S Decatur
CALCUTTA Atlanta
FRIENDS CAFE (Ladha Continental Hotel) Atlanta
SHERATON GARDENS INN . Decatur/Atlanta
CHOICE IS YOURS Atlanta
EL MEXICANO Atlanta
NORTH CHINA Norcross
DIMITRI'S Atlanta
MANDARIN RESTAURANT Riverdale
CRAB POT Roswell
NOT QUITE CRICKET Roswell
MIRAGE (Ladha Continental Hotel) Atlanta
BRAVO'S Chamblee
PANAMA PALACE Atlanta
RUE DE PARIS Atlanta
JEAN CLAUDE'S Marietta
FOUR SEASONS Roswell
EMILE'S FRENCH CAFE Atlanta
CHINA GARDEN Roswell
PRIME TIME Athens
LADHA DOWNTOWN HOTEL Atlanta
SIAM Tucker
ALFARO'S Atlanta
AUNT CHARLEY'S Atlanta
CHANESE GOURMET INN Atlanta
TOMORROW Atlanta
TJ'S Smyrna
ALPINE RESTAURANT Mableton/Atlanta
MARIO'S OF DORAVILLE Doraville
M.J. PIPPINS Atlanta
ERIC'S REEF & BEEF Marietta
GIGI'S (12 Locations) Atlanta
FRIENDS RESTAURANT Athens
MARIETTA DEPOT Marietta

18 RESTAURANTS
NEW TO THIS PROGRAM

35 Restaurants valid Friday...29 valid Saturday...23 valid Sunday...18 valid Lunch

Special Free Bonuses

TWO for the price of **ONE! ADMISSIONS: Roswell Village Theatre, Roswell Brannon Theatre, Buford Hwy Twin Theatre,** Atlanta: **Lawrenceville Triple Theatre, Douglasville Twin Theatre, Mableton Triple Theatre, Doraville Cinema, Griffin Quad. RENTALS: Lanier Island Houseboats, Lake Lanier. ACTIVITIES: Black Beard Yachts Sailing Course,** Darien, GA; **Rolling Rock Pleasure Cruise,** St. Petersburg, FL; **Drift Fishing,** Miami Beach, FL. **LODGING: Edgewater Beach Motel,** St. Petersburg, FL; **Hilton Inn,** Lauderhill, FL; **Holiday Inn, Carribbean Blvd.,** Miami, FL; **Holiday Inn, 79th St.,** Miami, FL; **Ladha Beach Hotel,** Savannah, GA; **Ladha Island Inn,** Jekyll Island, GA; **Runaway Bay Hotel,** Miami Beach, FL. **DINING: Boychik's Deli,** Atlanta; **HappenPappen's Deli,** Atlanta.

MEMBERSHIP

Here is something special designed for EVERYONE . . . you, your relatives, friends, neighbors, business associates, clients or employees. The Carriage Trade Dinner Club offers the Member an introduction to many of the Area's Finest Restaurants! Memberships may be ordered by mail or purchased at our office.

HOW IT WORKS

1. The Member is entitled to ONE FREE DINNER ENTREE in each of these OUTSTANDING RESTAURANTS when another dinner of equal or greater value is purchased at the same time.
2. YOUR CHOICE OF MENU! No Restrictions or Limitations!
3. Present your Membership Card ONLY when presented the Dinner Check.
4. All Restaurants honor the Membership during the week and many welcome Members on weekends.
5. Money Back Guarantee . . . Simply return all Membership material UNUSED within ten (10) days of receipt for a full refund.

EXECUTIVE OFFICES:
3281 Roswell Road, Atlanta, GA 30305
Phone: (404) 233-3113
Hours: 9 AM to 6 PM Monday thru Saturday

SIGNATURE _____

PLEASE BILL TO MY (CHECK ONE): ☐ VISA CHARGE ☐ MASTER CHARGE

master charge THE INTERBANK CARD

VISA

DATE EXPIRES: _____

ACCT. NO: _____

TELEPHONE # _____

TOTAL AMOUNT CHARGED $_____

PLEASE PRINT

The Carriage Trade Dinner Club®

Symbol of Excellence

3281 ROSWELL ROAD • ATLANTA, GEORGIA 30305 • TELEPHONE (404) 233-3113

I hereby apply for Membership in The Carriage Trade Dinner Club's exclusive Summer Fall Program. I am enclosing my check or money order for $20 for each Membership. It is understood that the Membership Card may be used starting June 1, 1980 and continuing thru November 30, 1980. I also understand that I may return all material UNUSED within ten (10) days for a full refund, if I am not satisfied.

NAME _____

ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

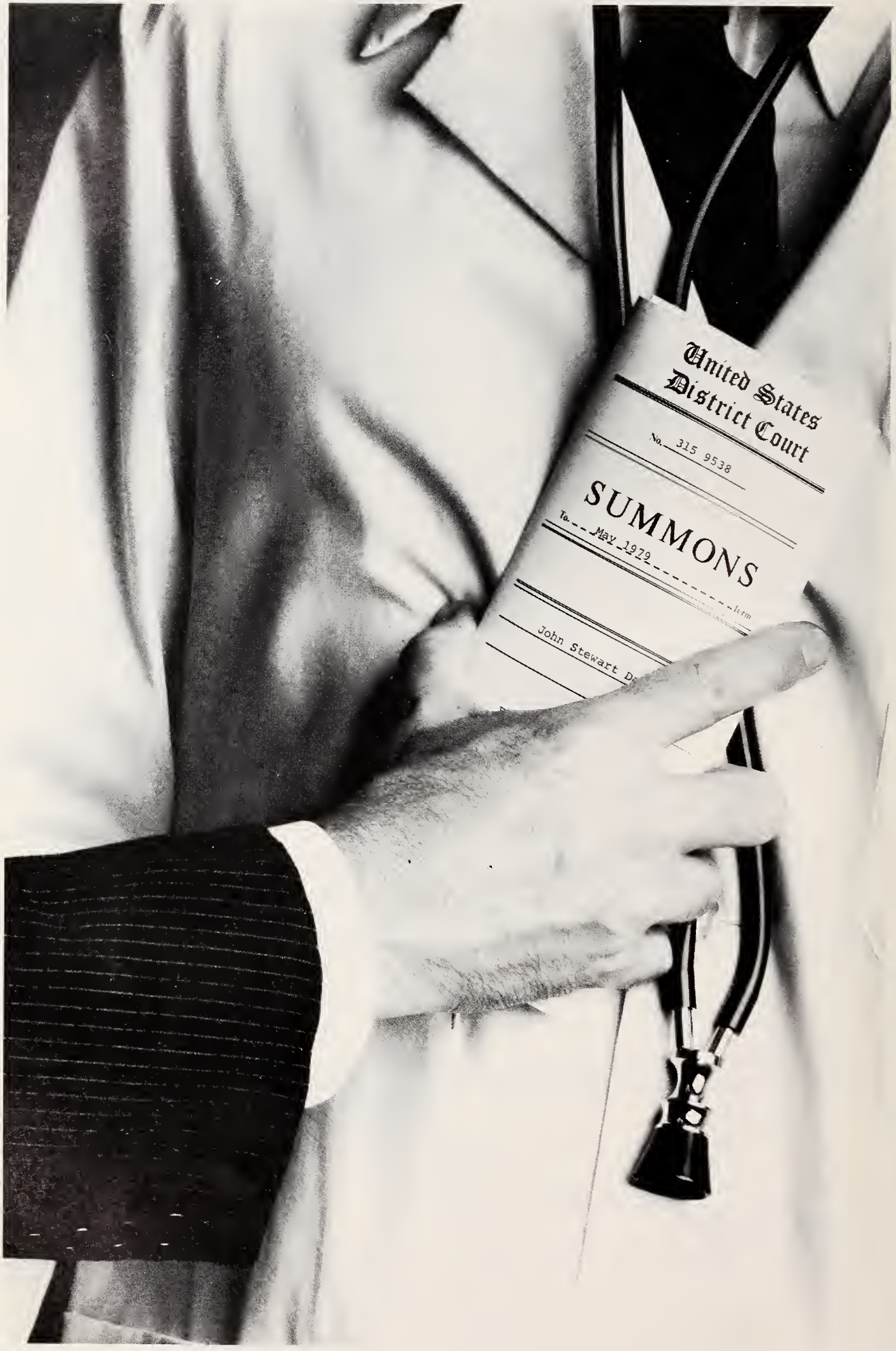
Gift Membership Print Person's Name to Receive Gift

NAME _____

ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

☐ SEND GIFT TO ME, ☐ SEND DIRECT, GIFT FROM _____


United States
District Court
No. 315 9538
SUMMONS
To - - May 1979

AFTER ALL THOSE YEARS OF HARD WORK, SOMEONE FINALLY HANDS IT TO YOU.

You're extremely vulnerable.

Because, along with achieving a good reputation, a nice-sized practice, and a large estate, you've become a prime target for malpractice claims.

And though you may get one that's of a frivolous nature, improperly handled it can cause enough pressure to affect you at work.

Which is why you may want to contact Insurance Corporation of America.

There are some specific reasons why we're better at helping you than other malpractice insurance companies.

AN ICA ATTORNEY. FROM THE START.

Legal action against a policyholder of ours is met head-on.

With legal action from us.

So, unlike other insurance companies, ICA doesn't give you a general adjuster who also handles auto liability claims.

Instead, even your initial phone conversation with ICA about a claim is with one of our licensed attorneys, seasoned in handling professional liability claims.

AFTER YOU CALL US, WE WON'T LEAVE YOU HANGING.

To help relieve the worries and frustrations a claim can bring you, we quickly become personally involved.

Soon after your call, we're discussing the claim face-to-face with you.

We also personally check every hospital record in a case, and act promptly on even a suspicion of a claim.

In so doing we're able to end many malpractice threats before they become formal suits.

And if a claim is formally lodged against you, your ICA attorney will bring together a task force drawn from the best, most experienced legal firms in the field of malpractice law.

He will coordinate the attorneys' efforts with those outstanding physicians who serve as ICA consultants.

And he'll be totally committed to fight until you get a favorable judgment or until all remedies by appeal or other proceedings are exhausted.

What's more, at ICA we never recommend that you settle just because it could be less costly than fighting.

WE TREAT $15,000-DOLLAR CLAIMS LIKE CLAIMS 100 TIMES BIGGER.

A small claim can do as much damage to a doctor's reputation as a big one.

And we're very sensitive to that fact. Because in addition to being operated by attorneys, our medical liability division is founded by an attorney who is also a physician.

So when it comes to protecting physicians, we're not only highly professional.

We're highly motivated.

And we hope that motivates you to fill in and mail the attached postage-paid form today.

ICA INSURANCE CORPORATION OF AMERICA

ICA Building, 2205 Montrose Blvd., Houston, Texas 77006, 713/526-4863

A:XV Reinsurance Protection Provided.

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Both common and rare entities of dermatology are discussed along with some newer concepts of diagnosis and treatment.

Current Trends in Dermatology

DONALD J. PIROZZI, M.D., *Atlanta**

Introduction

DERMATOLOGY is a constantly enlarging speciality with many new developments taking place on all frontiers. The purpose of this paper is to consider some newer concepts and treatments of a few common and some unusual skin diseases.

Psoriasis

Psoriasis is a common disorder of the skin affecting approximately 2% of the white population. It is a rapidly proliferating condition, usually manifesting itself with infiltrated plaques with overlying scales anywhere on the body but particularly on the knees and elbows (Figure 1). Many anti-inflammatory agents have been used in the treatment of the disorder, including topical and systemic steroids and coal tar. Also of benefit is Methotrexate which stops the rapid proliferation of cells causing the plaque-like condition. One of the newer modalities used to treat the disease is PUVA (*p*soralen & *u*ltra*v*iolet *A* light). With this method, the patient ingests a given quantity of eight methoxy psoralen and then receives a predetermined exposure to UVA light. This form of ultraviolet light is in the long wave spectrum of light and activates the psoralen compound in the skin supposedly causing the cell proliferation to stop. This therapy, though very effective, has deleterious side effects. Long-term usage may cause cataracts or increase a patient's susceptibility to skin cancer since the patient is receiving a larger dosage of ultraviolet light. Continued research is aiming toward more potent oral antagonists of the rapid cell proliferation.



Figure 1 — Typical psoriasis, showing infiltrated papulosquamous plaques.

Zoster (Shingles)

Zoster or shingles (Figure 2) is an annoying and possibly serious illness at any age but is especially so in those patients over 40 years of age. It is a condition caused by the varicella-zoster virus. It usually occurs in persons having partial immunity to the virus, that is, in those who have had chicken pox or at least developed some antibodies to it. Characteristically, the disease manifests itself as grouped vesicles on an erythematous base generally asymetrical



Figure 2 — A case of zoster with grouped vesicles on an erythematous base along several dermatomes.

* Dr. Pirozzi practices dermatology. His address is 105 Collier Rd., NW, Atlanta,GA 30309.

and involving one or more dermatomes. Usually the skin lesions occur along the skin following the dermatome. It is thought that the virus causes the pain usually present by invading the nerve root and causing inflammation. If the inflammation continues, then scarring can occur, and the pain may be permanent. If the condition involves the first branch of the trigeminal nerve, corneal damage and possible blindness may result. In the older age group, who seem more susceptible to permanent damage of the nerve root, it is suggested that some form of treatment that would be anti-inflammatory be used. Thus, the use of systemic steroids has been advocated. Intramuscular Triamcenolone Acetonide or oral Prednisone can be safely used in a non-immunosuppressed patient, and this will many times hasten the healing of the lesions and prevent the unwanted sequelae.

Herpes Simplex

Herpes Simplex (Figure 3) remains the bain of all specialties. It is caused by a virus, is persistent in the skin, and is difficult to treat. This becomes most significant when the infection involves genital areas. Recently, many therapies have been attempted, all with little success. There are some symptomatic methods, however, which have merit. Intramuscular injections of gamma globulin at the time of recurrence of infection have been useful in certain patients both to shorten the course of the eruption and to possibly extend the time between attacks. The use of zinc oxide paste at the time of attack can be helpful and definitely helps the lesion to dry more quickly. Also, it is noted that the herpes lesions are invariably secondarily colonized with staphylococcal organisms which prolong the course of the infection, and thus an anti-staph medication often shortens the attack. Most recently, L-Lysine has been used orally with surprising benefit, usually preventing continual occurrences of the illness. It must be stated, however, that any consideration of a medication which supposedly prevents recurrences of Herpes Simplex is difficult to evaluate since the disease is not predictable; that is, there is no regularity to recurrences, and thus one cannot say for sure whether any agent is preventing the eruption from recurring.



Figure 3 — Discrete grouped vesicles, typical of Herpes Simplex.

Vasculitis

Another area of skin disease to be discussed, not because of novelty of treatment but because of difficulty in understanding or diagnosing, is vasculitis. The term vasculitis refers to an inflammation of blood vessels. This can be as simple as the reaction one sees with penicillin allergy to as complicated and devastating as polyarteritis nodosum. Vasculitis can be secondary to an allergic reaction from medications or foods or can occur as an "idiopathic" immune complex reaction, such as occurs in polyarteritis nodosa. Generally, the skin lesions are very typical, being erythematous papules or nodules which may ulcerate and are usually painful. The more severe forms of the disease, such as Henoch-Schoenlein purpura or polyarteritis nodosa, generally have distinctive and severe systemic symptoms; however, some cases of urticaria may show a vasculitis and by comparison be much less severe symptomatically. Treatment of these diseases involves the elimination of any predisposing factors and the use of such simple remedies as antihistamines or more potent agents, such as systemic steroids or possibly even anti-immune agents, such as Immuran or Cytoxan.

Basal Cell Carcinoma

Basal cell carcinoma is a low-grade malignancy usually found on areas of the skin which are exposed to the sun. The lesions characteristically manifest as ulcers which do not heal or atrophic lesions on grossly sun-damaged skin (Figure 4). Generally, these types of cancer do not metastasize and are readily cured by simple removal of the lesion. At times, however, these may appear in areas considered difficult to surgically extirpate (such as the naso labial folds or inner canthi of the eyes), or they may recur.



Figure 4 — A basal cell carcinoma, showing an ulcer with surrounding pearly border.

It is at this time that a new procedure called chemosurgery may be useful. With this technique, the operator maps out a grid of the lesion and then removes the lesion in a horizontal plane with the help of chemicals or just by removing the tissue. He then immediately analyzes the tissue microscopically, making sure to orient it as to the previously drawn grid. Thus he can determine which section still has tumor in it. He then goes back to the "positive area" and repeats the process as many times as necessary to assure that no cancer remains. This technique can also be used with squamous cell carcinoma of the skin and any other low-grade, slow-growing tumor.

COLLAGEN VASCULAR DISEASES

This is an interesting and most unusual group of illnesses, thought to be auto-immune reactions. The conditions can be very severe and are tied together by all having some changes in the skin that are often the initial findings of the diseases.

Lupus Erythematosus

Lupus erythematosus is a most devastating condition which can involve most of the internal organs and often is first diagnosed by some peculiar skin changes. The one most commonly referred to is the "butterfly rash." This is a noticeable erythema with some atrophy of the skin over both malar areas of the face and the bridge of the nose (Figure 5). Chronic urticaria that is unresponsive to normal therapy may usher in any of the collagen vascular diseases, but especially lupus erythematosus. There are some peculiar patterns of hair loss, such as frontal breaking off of hair, diffuse loss of hair, or scarring alopecia, which may harbinger lupus erythematosus. Hemorrhagic telangiectasia on the hands and face may be a contributory sign of lupus erythematosus or the other collagen vascular diseases. Some tests, such as a lupus erythematosus prep or an ANA, are helpful in diagnosis and can even help gauge the effectiveness of the treatment. Therapy for lupus erythematosus includes the use of the anti-inflammatory agents, such as systemic steroids, or cytotoxics, such as Immuran. If caused by drugs such as Hydralazine or Procainamide, elimination of the agent can often relieve the condition. Antimalarial agents, such as chloroquin or hydroxychlorquin, can often be useful in treating the associated vasculitis.

Scleroderma

Scleroderma is another of the so-called collagen vascular diseases which has many manifestations on the skin. It is characterized by infiltration of the skin and some fairly characteristic vascular changes. Histopathologically, one sees an infiltration of new connective tissue in the dermis and subcutaneous areas which gives the impression of fibrosis. The skin appendages are basically destroyed, and this accounts for the non-pliability of the skin clinically. The first sign of this disease is often edema of the skin and possibly telangiectasis of the face or extremities. This can rapidly progress to infiltration and fibrosis of the skin with characteristic changes in the facies (Figure 6). Raynaud's phenomenon is often an early sign of the condition, as well as the other collagen vascular diseases, and calcium is often deposited in the damaged skin giving rise to so-called calcinosis cutis. Just as collagen or fibrosis tissue is deposited in the skin so too can it be diffused between the alveoli of the lungs and in the submucosa of the lower esophagus or other parts of the intestine. This is usually manifested by food "sticking" in the lower esophagus, increased transit time through the intestine, and difficulty breathing. As was said earlier, the clinical appearance of long-standing scleroderma is somewhat dramatic. The patients stare straight ahead with a fixed facies, often with noticeable telangiectasias (Figure 7), hard skin, and, if the extremities have been sufficiently damaged by Raynaud's phenomenon, a claw hand. Tests that are occasionally helpful are a barium swallow and upper gastrointestinal series which



Figure 5 — A patient with systemic lupus erythematosus with characteristic butterfly rash.



Figure 6 — Infiltrated and sclerotic skin, typical of systemic sclerosis.



Figure 7 — Typical facial expression in a person with scleroderma, manifesting a smooth, infiltrated non-wrinkled brow and an expressionless stare.



Figure 8 — A patient with dermatomyositis, characterized by an edematous, violaceous, "heliotrope" eruption.

show the decreased transit time. An ANA which shows a speckled pattern can often help in the diagnosis. Therapy for the disease is not satisfactory. Generally, one concentrates on physical therapy and treating many of the complications that arise. Systemic steroids and cytotoxic agents can be helpful early in the course of the disease, and occasionally vasodilators or sympathectomy can give temporary relief. None of these therapies, however, is long acting or curative.

Dermatomyositis

Dermatomyositis is another collagen vascular disease characterized by inflammation and weakness of muscles (proximal) as well as by a distinctive rash. The condition again is thought to be autoimmune, and especially in those over age 40 may be an indication of internal malignancy. The characteristic edematous eruption over the upper part of the face including the eyelids is pathognomonic of the disease (Figure 8). A change over the joints of the fingers is also characteristic. These lesions are usually erythematous papules found on the dorsum of the hands and are known as Gottron's papules (Figure 9). Again, chronic urticaria may be an initial sign of the disease. Laboratory tests are generally not too helpful, although elevated muscle enzymes, such as CPK and aldolase (which occur because of the myositis), can lead to the diagnosis when corroborative evidence such as a muscle biopsy and electromyographic tests are positive. Treatment involves the use of steroids or cytotoxics and the elimination of the malignancy if present.

LYMPHOMAS AND OTHER DISORDERS

Cutaneous changes probably occur in as many as 50% of patients with lymphomas. These lesions can be either specific or nonspecific. Such diseases as reticulum cell sarcoma or lymphosarcoma can manifest as collections of the typical malignant cells in violaceous or pink papules, or nodules or tumors occurring in the superficial dermas to the subcutaneous layer. These skin lesions are often the first sign of the disease before it spreads to involve the viscera. Nonspecific lesions and symptoms, such as pruritis, ichythosis, bullous eruptions and exfoliation of skin, can occur with any of the monomorphous lymphomas but occur more so in the polymorphous Hodgkin's lymphoma. Erythema multiforme may be another reaction pattern of the lymphomas. Hyperpigmentation is also often found as a nonspecific marker of lymphoma and especially in Hodgkin's disease.



Figure 9 — Gottron's papules, which are pathognomonic for dermatomyositis.

Before discussing a more typical skin malignancy there are two pseudo malignancies that necessitate discussion. Anticonvulsant therapy with Dilantin, Mesantoin, and other related compounds can produce fever and lymphadenopathy which is often interpreted as lymphoma, and is often confirmed by a lymph node biopsy. In addition, lymphocytoma cutis usually manifests itself as a violaceous plaque on the face, and biopsy often shows a proliferation of lymphocytes. They are all mature, however, and the condition is amenable to treatment.

Mycosis Fungoides

Mycosis fungoides is a very unusual and confusing lymphoma because it is for many years of its course confined to the skin. There are three phases of the disease: (1) An eczematous or premycotic stage which can persist for many years and is generally pruritic. Exfoliative dermatitis or erythroderma often with edema are often seen at this stage. (2) A plaque stage where the premycotic eczematous lesions become infiltrated lesions or the whole integuement becomes infiltrated with lymphoma cells. Alopecia of the involved areas usually occurs at this stage. (3) A tumor stage which can develop from pre-existing plaques, erythroderma, or uninvolved skin. Tumors are usually a sign of a true malignant lymphoma which also affects the internal organs. This was also the stage which gave the disease its name, for early investigators likened the tumors to mushrooms, thus "mycosis fungoides."

The disease can be diagnosed at all stages but more easily in the plaque or tumor stage when histopathologic corroboration occurs. A polymorphous infiltrate of lymphocytes, histiocytes, plasma cells, eosinophils, and polymorphonuclear leukocytes occurs as a dense band in the upper dermis and is quite characteristic of the disease.

Treatment of the disorder is not very effective. In the early stages, however, systemic steroids or psoralen and long-wave ultraviolet light can be beneficial. Much chemotherapy, such as topical nitrogen mustard, has been used on the disease but is usually only effective for very short periods of time. Once the condition affects the internal organs, treatment is not effective and becomes mostly symptomatic in approach.

It is hoped that discussing some of these common and rare entities of dermatology that the reader will be given some newer concepts of diagnosis and treatment. Skin disease, though at times somewhat confusing, can certainly be the first indication of more serious internal illness and by applying some simple visual principles may lead to more effective treatment of the patient.

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

Psychiatric Institute of Atlanta • 811 Juniper St. NE, Atlanta, Ga. 30318 • 873-6151

Morris E. Chafetz, M.D.,
Founding Director of the National
Institute on Alcohol Abuse and Alcoholism,
is pleased to announce
the opening of a private
residential alcoholism treatment facility
in Charleston, South Carolina.



FENWICK HALL

John H. Magill, Executive Director. Layton McCurdy, M.D., Medical Director. Phone 803-559-2461.



Tagamet®

brand of

cimetidine

How Supplied:

Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

SK&F LAB CO.
a SmithKline company

Perdiem™

empties the bowel gently...

by filling it.

Perdiem™ . . . the re-educative laxative . . . relieves constipation by a unique combination of physiological bulk stimulus and gentle pharmacologic encouragement of peristaltic response.



WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Sluggishness of the Bowels

Constipation

Chronic Constipation

Habituation to Laxatives

Abuse of Laxatives



Made in West Germany

(Please see next page for prescribing information)

Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

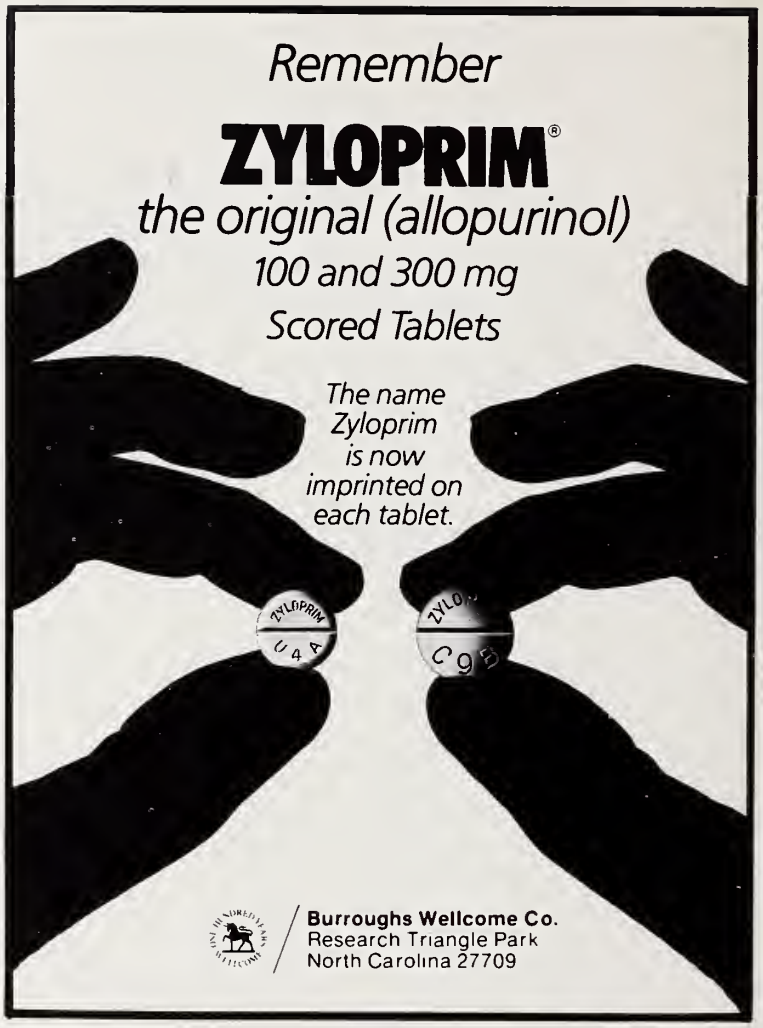
FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

ROER

WILLIAM H. RORER, INC.
Fort Washington, PA 19034



pepi

The Physical Education Public Information (PEPI) Project is a public service campaign developed by AAHPER to inform Americans about the value and benefits of school physical education programs.

The creation of these public service advertisements was made possible through the generosity of the Gillette Company, Safety Razor Division. Selected photos courtesy of the 1975 Scholastic/Kodak Photography Awards.

On behalf of our 50,000 professional members, we solicit the cooperation of publishers in bringing these public service messages to the public. Advertisements have been provided in a variety of sizes and we hope you will use them on a space available basis.

AAHPER

American Alliance for Health, Physical Education & Recreation
1201 16th Street, N.W.
Washington, D.C. 20036

L-Asparaginase and Toxic Epidermal Necrolysis

ANTONIO R. RODRIGUEZ, M.D., *Augusta**

Abstract

An adult patient with acute lymphoblastic leukemia (ALL) treated with L-asparaginase died from toxic epidermal necrolysis (TEN). Since this skin disorder has a high mortality rate, it is important to report any possible association between L-asparaginase and TEN in cases of adult ALL.

Case Report

A 35-YEAR-OLD-MAN was admitted to the Medical College of Georgia (MCG) hospital for treatment of ALL in relapse. He had been in complete remission for 2 years after chemotherapy with vincristine and prednisone. He was maintained on methotrexate and periodic pulses of Adriamycin, vincristine, and prednisone. Intrathecal methotrexate and cranial irradiation were given for central nervous system prophylaxis. After experiencing a relapse 6-months ago, the patient was treated with vincristine and prednisone, followed by several courses of cyclophosphamide, vincristine, cytosine arabinoside, and prednisone (COAP). This therapy, however, was unsuccessful. He was then tried on L-asparaginase *(Escherichia coli)* 1,000 units/kg daily intravenously for 10 days. On the 11th day after starting the treatment, skin lesions developed over the extremities and lumbrosacral region and consisted of macular and flaccid bullae. The Nikolsky sign (slippage of the epidermis when lateral stress is applied to it) was present. A diagnosis of TEN was made. A skin biopsy was not done, since the diagnosis did not appear to be in doubt.

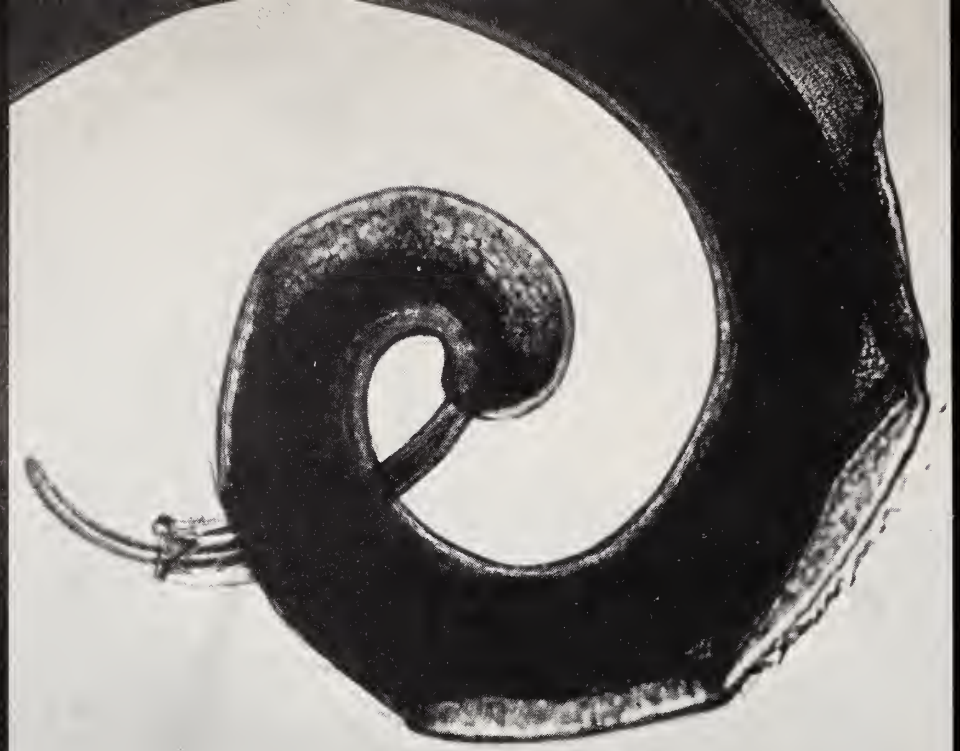
There was no evidence of staphylococcal infection. The chest x-ray did not show pneumonia. Several cultures and gram stains of blood, skin lesion, urine, stool, sputum, and cerebrospinal fluid specimens were negative. Oxacillin was given empirically to prevent a possible staphylococcal infection. The patient had been on 40 mg daily of prednisone for his leukemia. Steroids have been used in the treatment of drug-induced TEN, yet this did not prevent the onset of this disease in this patient. The prednisone was tapered down to 10 mg/day, since it did not appear to be useful. In fact, it may predispose a person to secondary infection especially in one who is immuno-suppressed. The skin lesions became more widespread, requiring burn-care treatment with Silvadene cream and parenteral fluid and electrolytes. The patient deteriorated rapidly, however, and died 3 days later in shock and from respiratory arrest. No autopsy was done.

Discussion

TEN is a life-threatening skin disorder characterized by erythema, epidermal loosening and stripping, and a scalded appearance. The denuded areas of skin may be so extensive that fluid and electrolyte losses may result in shock. Secondary infection, as with burns, may also be a problem. The disorder has a mortality rate of 20 to 50%, even when recognized and treated promptly.[1, 2] It has been associated with staphylococcal infection and various drugs, or it may be idiopathic.[1, 2] Although L-asparaginase has several serious side-effects, TEN has not been mentioned in many reviews of this drug.[3, 4, 5]

(Con't on p. 357)

* Dr. Rodriguez is Assistant Professor of Medicine, Department of Medicine, Section of Hematology/Oncology, Medical College of Georgia, Augusta, GA 30912. Send reprint requests to him at that address.



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX®.

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

© Janssen Pharmaceutica Inc. 1980

JPI-023



Broad-spectrum coverage in mixed helminthic infections

TABLETS
Vermox®
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

(L-Asparaginase — con't from p. 355)

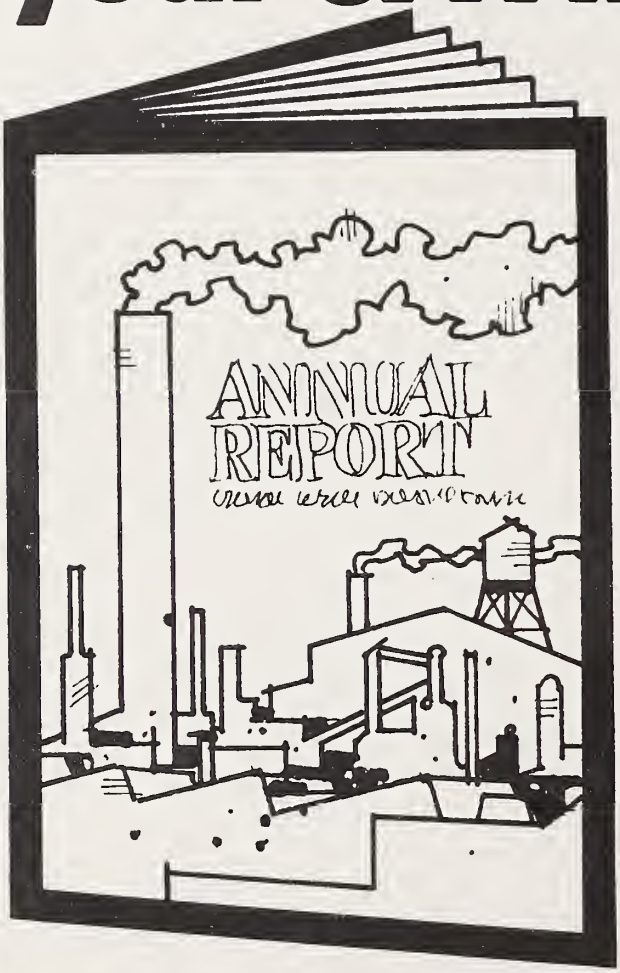
It is possible that ALL may be associated with TEN. One case of ALL was reported to involve this skin disorder, But this was thought to be due to graft-vs-host reaction.[6] The other possibility is that our patient had TEN induced by L-asparaginase. The time sequence of its appearance is within the range of previously reported drug-induced TEN.[1] All the other drugs that the patient received within 1 month from development of TEN, including allopurinol, compazine, and isoniazid, were ones that he had taken repeatedly in the past 2 years. Antibiotics have been particularly implicated in drug-induced TEN, and this patient had received Amikacin and carbenicillin. However, he had also received penicillin and aminoglycoside derivatives in the past. A Tzanck preparation is helpful in defining further the etiology of TEN. However, this was not done. It is of note that steroids have been used in the treatment of drug-induced TEN, yet this did not prevent the onset of this disease in this patient.

The incidence of TEN is lower in adults and is partly due to better immune capabilities.[7] Perhaps this patient's leukemia, with its well-known impairment of immune function, may have contributed to the development of TEN. It is noteworthy that the patient was 35 years old, an unusual age for ALL, and was probably one of the older patients to receive L-asparaginase. The combination of an adult patient with ALL, undergoing L-asparaginase therapy, and the development of TEN is unusual enough to merit attention and further observation to note if there is indeed any such association.

References

1. Lyell A. Toxic epidermal necrolysis (the scalded skin syndrome): A reappraisal. Br J Dermatol 1979; 100:69-84.
2. Neefe LI, Tuazon CV, Cardela TA, Sheagren, JN. Staphylococcal scalded skin syndrome in adults: case report and review of the literature. Am J Med Sci 1979; 277:99-110.
3. Oettgen HF, Stephenson PA, Schwartz MK, et al. Toxicity of E. coli L-asparaginase in man. Cancer 1970; 25:253-278.
4. Capizzi RL, Bertino JR, Handschumaker RE: L-asparaginase. Ann Rev Med 1970; 21:433-444.
5. Land VJ, Sutow WW, Fernbach DJ, et al. Toxicity of L-asparaginase in children with advanced leukemia. Cancer 1972; 30:339-347.
6. Peck GL, Herzig GP, Elias PM: Toxic epidermal necrolysis in a patient with graft-vs-host reaction. Arch Derm 1972; 105:561-569.
7. Elias PM, Fritsch P, Epstein EH. Staphylococcal scalded skin syndrome. Clinical features, pathogenesis, and recent microbiological and biochemical developments. Arch Dermatol 1977; 113:207-219.

how do others make more profits? your CPA knows.



Financial structuring, budgeting and forecasting, and short and long range planning are just a few of many services performed by Certified Public Accountants (CPAs) that can prove profitable whether you are a one man operation, partnership, or corporation. In the process of auditing, CPAs scrutinize your internal control systems, cash flow, depreciation of assets, securities, inventory valuations, contracts, leases, insurance, tax reserves, and related information concerning your financial position and operating results.

Certified Public Accountants are professionals authorized by law to perform the full range of accounting services. For help in increasing your profitability consult the Yellow Pages under "Accountants – Certified Public."

Ask a CPA, and be sure

CPA

Georgia Society of Certified Public Accountants

6403

Calculi in a Non-Functioning Kidney

LETITIA CLARK, M.D., ROY M. WALLER III, M.D., AYTEN SOMEREN, M.D., *Atlanta**

Dr. Letitia Clark: This patient was a 40-year-old woman who presented with a 3-week old history of dull and aching right flank pain, weight loss of approximately 20 lbs., and an intermittent low-grade fever. There was no history of dysuria or hematuria. An oral cholecystogram was performed, and the findings were normal. Dr. Waller would you discuss this case?

Dr. Roy Waller: This 1-hour film from an excretory urogram (Figure 1) demonstrates good excretion on the left, with a kidney of normal size and shape and a normal upper urinary collecting system. The bladder is well opacified at 1 hour and has a normal contour without evidence of intrinsic filling defects. There is a large, laminated calcific density overlying the right renal shadow near the renal pelvis and ureteropelvic junction, with several other smaller, laminated calcific densities scattered over a diffusely enlarged non-functioning right kidney. Given the negative oral cholecystogram, I would conclude these densities represent opaque renal calculi within the pelvocalyceal system.

Given these roentgenologic findings of a non-functioning enlarged right kidney with multiple radiopaque calculi, and the clinical presentation of right flank pain, weight loss and fever, several renal pathological entities deserve mention. These entities will be discussed under five major categories. They are: neoplastic, vascular, obstructive, infectious, and traumatic renal lesions.



Figure 1 — One hour excretory urogram film, demonstrating non-functioning right kidney with calculi. The left upper urinary tract appears normal.

Neoplastic

First of all, renal cell carcinoma, with pre-existing renal calculi, and renal vein obstruction secondary to tumor extension, or massive arteriovenous shunting within a large tumor mass could present similarly. Non-function secondary to tumor replacement of kidney is uncommon in renal cell carcinoma, but this is a unique occurrence with a transitional cell carcinoma of the pelvocalyceal system. With this phenomenon, there is destruction and replacement of the functioning nephron mass by either tumor or its fibrous reactive process.

Vascular

Renovascular catastrophies such as renal vein occlusion could produce an enlarged, non-functioning kidney in the acute phase. A large renal arteriovenous fistula, congenital or post-traumatic, is sometimes associated with a non-functioning kidney. The absence of suggestive history militates against these vascular entities accounting for the case presented here. Also, there is no history suggestive

* Drs. Clark and Waller are from the Department of Radiology, Emory School of Medicine, Atlanta, GA 30303. Dr. Someren is from the Department of Pathology, Emory University School of Medicine, Atlanta, GA 30303. This is from a weekly x-ray conference, Department of Radiology, Emory University School of Medicine. The conference material was edited by Drs. J. L. Clements and H. S. Weens.

of blunt abdominal trauma with resultant renovascular pedicle injury or avulsion, or non-opacification of the kidney secondary to fractured parenchyma, the so-called "shattered kidney."

Obstruction

Obstruction of the ureter by calculus, stricture or transitional cell neoplasm with the resultant hydronephrosis of the kidney, could also present urographically as a non-opacified, large kidney.

Infections

Among infectious etiologies to account for this roentgenologic finding, calculus pylonephrosis is a possibility, and can present with an enlarged renal shadow with no function on the excretory urogram. Foremost among the infectious considerations which would account for the findings on the presented case is xanthogranulomatous pyelonephritis, which is an unusual variant of chronic pyelonephritis, most often presenting radiographically as an enlarged, non-functioning kidney with calculi, often a large staghorn calculus. A significant majority of affected patients are females, usually past middle age, and presenting symptoms include a long history of urinary tract infection, almost invariably flank pain and fever, and in about half the cases significant weight loss and a palpable mass. This clinical presentation often closely mimics that of a renal neoplasm.

Renal Lesions

Urographically, two forms of xanthogranulomatous pyelonephritis are recognized. The tumefactive type presents as a solitary, localized renal mass which on angiography may demonstrate bizarre neovascularity with puddling of contrast, simulating a renal cell carcinoma. An avascular pattern has been described which mimics a necrotic renal cell carcinoma. The second form of xanthogranulomatous pyelonephritis is a diffuse infiltrative process which is usually associated with generalized renal enlargement with hydronephrosis and angiographic evidence of spreading renal arterial branches about multiple radiolucent defects in the kidney which may represent either dilated calyces or the actual xanthogranulomas. Occasionally there will be evidence of fine, reticular neovascularity with encasement of vessels, again making differentiation from a renal neoplasm difficult.

In conclusion, this entity of xanthogranulomatous pyelonephritis most likely accounts for the clinical and roentgenologic finding in this case, and it should be the primary diagnosis suggested by the radiologist.

Dr. Letitia Clark: Thank you, Dr. Waller. Dr. Someren, would you please discuss the pathology?

Dr. Ayten Someren: The gross specimen consisted of a kidney which weighed 200 grams and measured 11 x 6 x 5 cm. Large amounts of fibroadipose tissue was present, attached to the capsule which stripped with difficulty from the cortical surface revealing broad-based scars. On the cut surfaces, the renal pelvis and calyces appeared dilated and contained several calculi. The papillae were lost, and the expanded calyces were lined by yellowish zone, which on the inner aspect appeared friable (Figure 2). The cortex was reduced and firm in consistency.

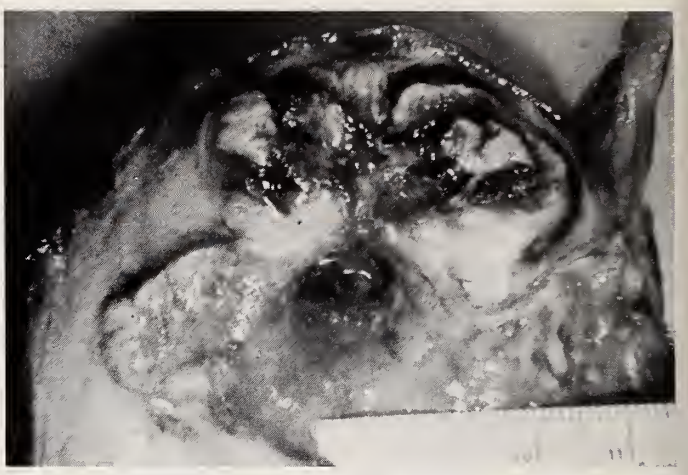


Figure 2 — Gross specimen of xanthogranulomatous pyelonephritis, demonstrating confluent nodules of partly necrotic tissue lining dilated calices.

Histologically, the areas nearest to the calyces showed necrotic debris intermingled with polymorphonuclear leukcytes. The surrounding yellow areas contained an admixture of large foam cells with PAS positive finely granular cytoplasms, plasma cells, lymphocytes, fibroblasts, and polymorphonuclear leukocytes. Scattered multinucleated giant cells and cholesterol crystals were also present. The peripheral parts abutting on the non-infected renal parenchyma showed fibrosis. The surrounding cortex showed tubular atrophy, interstitial fibrosis, and infiltration with chonic inflammatory cells. These gross and microscopic findings were considered typical of xanthogranulomatous pyelonephritis.

This disorder is a form of chronic pyelonephritis which has become increasingly well recognized in the last 10 years. It is important because it may be mistaken for renal cell carcimoma. For this reason, it has attracted the attention of radiologists in particular. It is found more commonly in women and can occur at any age. It is usually accompanied by fever, flank pain, palpable mass, and leukocytosis. Weight loss may also be present. Proteus species are the most commonly cultured organisms from the urine, but others such as *Escherichia coli*, Aerobacter, and staphylococci may also be the etiologic agents. It is usually unilateral.

Xanthogranulomatous pyelonephritis is undoubtedly of infectious origin, and its particular

appearance is thought to be secondary to the interference with drainage. Foamy macrophages, many of which contain PAS positive granules, are related to the bacterial products.

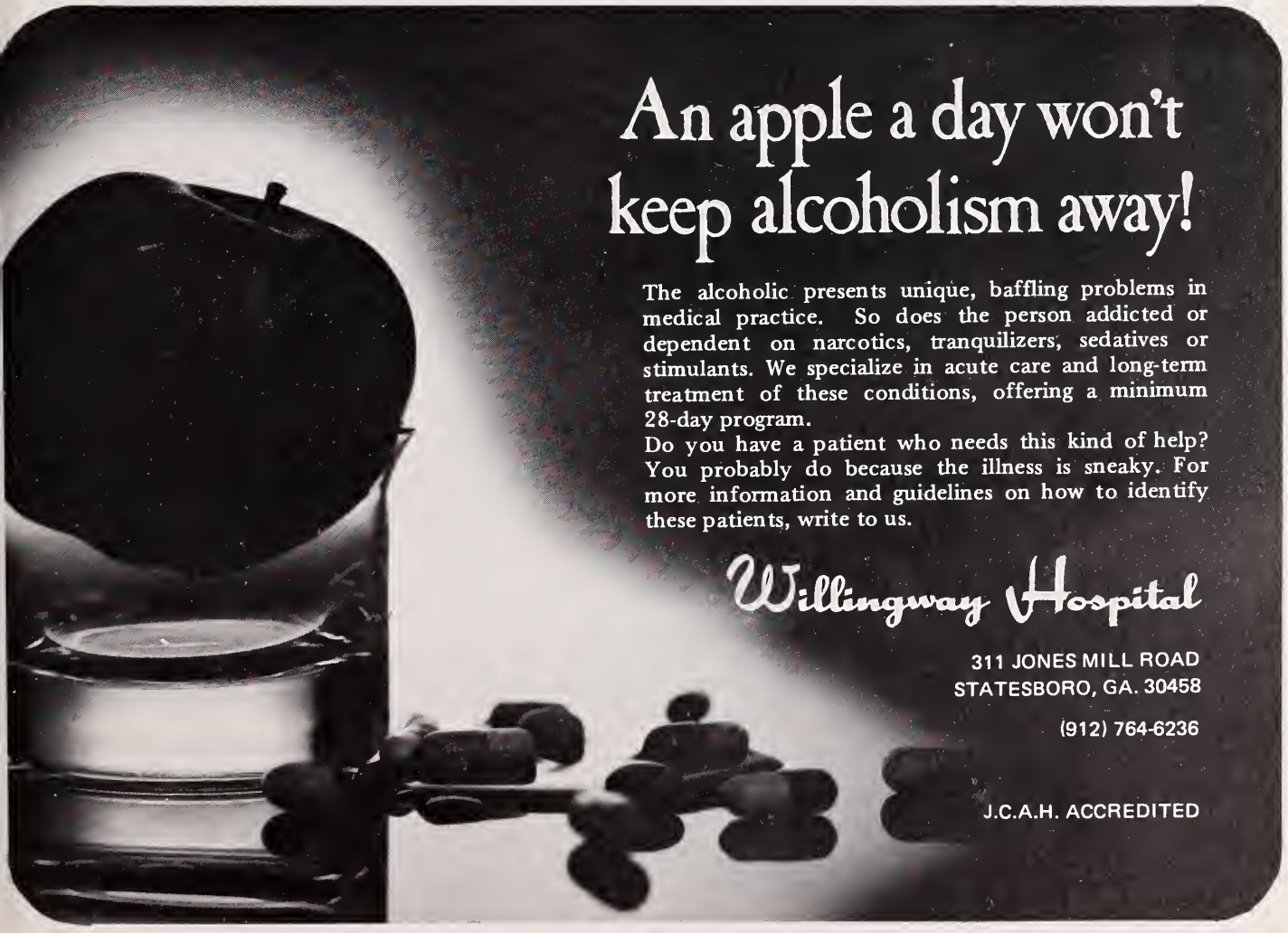
Grossly, xanthogranulomatous pyelonephritis, with its sometimes confluent nodules, showing peripheral yellowish, wavy bands, and central necrosis, may mimic renal cell carcinoma, but it lacks the variegated appearance of the latter. Histologically, the foamy histocytes of xanthogranulomatous pyelonephritis may simulate the clear cells of renal cell carcimoma, but they show no acinar formations. Also, they are intermingled with other acute and chronic inflammatory cells and multinucleated giant cells. In addition, there is usually little or no stroma present, and the vascularity of renal cell carcinoma is absent.

Comment

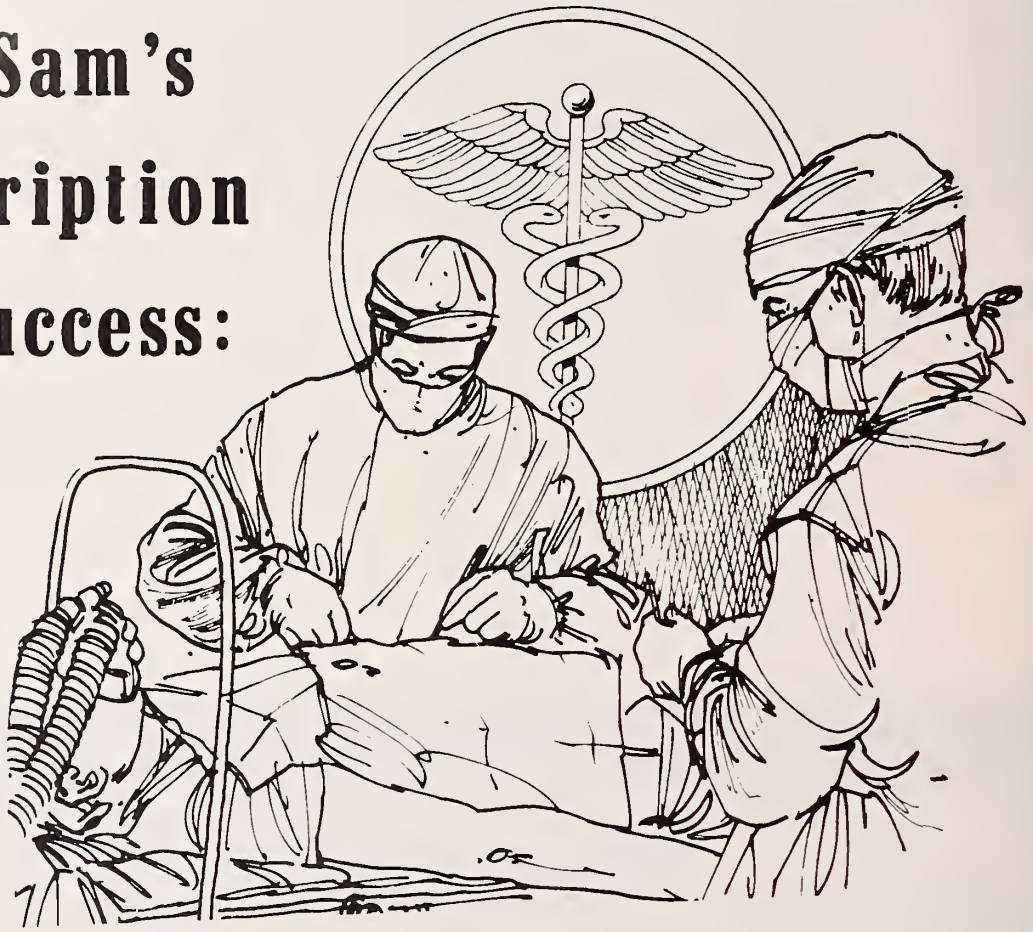
Urographically, xanthogranulomatous pyelonephritis may present as a diffuse infiltrative process or as a localized, tumefactive form. In the tumefactive type, urography and nephrotomography may demonstrate a solitary, space-occupying mass lesion, suggesting renal cyst, abscess, or tumor. Angiographic findings usually demonstrate the obstructive and inflammatory process present in the kidney. Angiographic findings are often difficult to differentiate from a renal cell carcinoma. A nonfunctioning, enlarged kidney with calculus disease is a common roentgenologic triad in this unusual entity of xanthogranulomatous pyelonephritis.

References

1. Becker J. Xanthogranulomatous pyelonephritis; Acta Radiologica 1966; 4:139-144.
2. Elkin M, et al. ACR GUII Syllabus 1976; pp. 136-142.
3. Emmit J, Witten D. *Clinical Urography*. Third Edition. Philadelphia: W.B. Saunders Co., 1977, pp. 839-843.



Uncle Sam's Prescription For Success:



Medicine and the Ga. National Guard

As a physician in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found...service to community, state and nation.

In addition, many persons have found that the change of place and change of pace have resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for the Georgia Army National Guard units. Physicians receive monetary support for attending approved CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. **WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS.** If you need that **CHANGE OF PLACE** and **CHANGE OF PACE**, contact:

ARMY NATIONAL GUARD
The Guard belongs.

Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

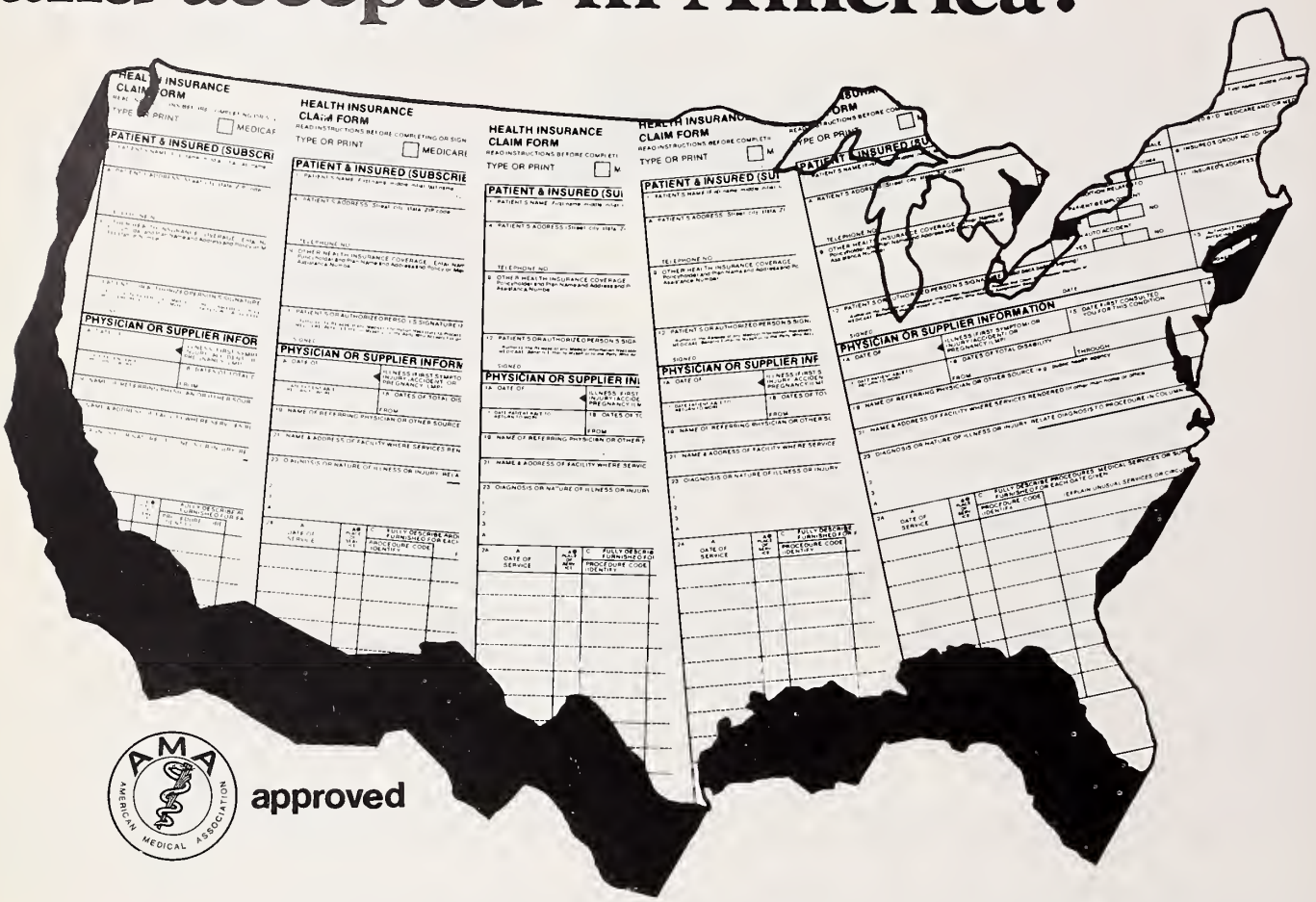
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc.
Manati, Puerto Rico 00701

This insurance claim form is the most widely used and accepted in America.



Are you using it?

If you're not using the Official AMA Uniform Health Insurance Claim Form, chances are you should be. It is accepted by all states for Medicare, many states for Medicaid, and almost all commercial carriers and Blue Shield Plans.

Developed by the AMA in cooperation with carriers, government agencies, and other groups, it is the most current and universally used reporting form available.

And it can save you and your staff a lot of time. You use just one form—one format—for most of your reporting instead of having to decipher a bunch of different ones.

Be sure you get the *Official* AMA Health Insurance Claim Form; mail this order form with your payment today.

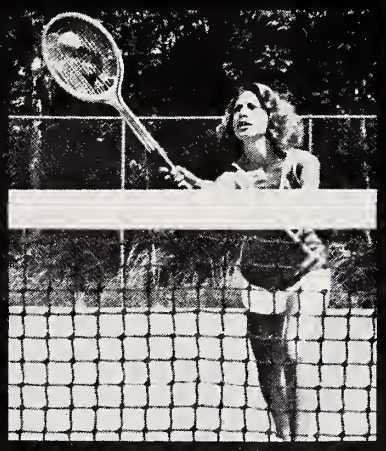
ORDERING INFORMATION

Type of Form	Quantity*	Price per thousand
() Single Form, OP-407 (In pads of one hundred)	1,000-25,000	$23.10
() Snap-out Form, OP-408 (Original and carbon)	1,000-25,000	$35.20
() Continuous Computer Form, OP-409 (Original and one carbon)	1,000-25,000	$36.00
	TOTAL	_____

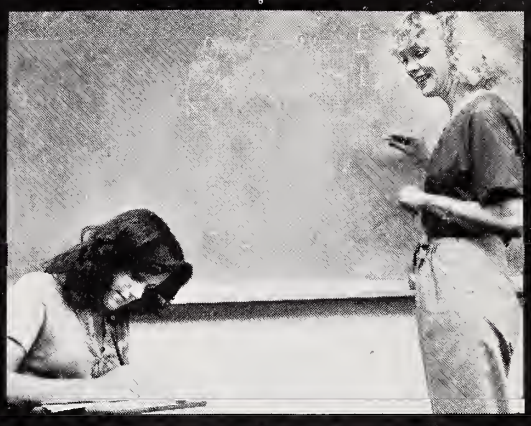
*NOTE: Larger quantities available at special rates. Write to: Order Handling, AMA, 535 N. Dearborn, Chicago IL 60610

To order: Indicate type of form and quantity desired, compute total cost, and send order, accompanied by check or money order (payable to the American Medical Association), to the address below:

Order Department
American Medical Association
P. O. Box 821
Monroe, Wisconsin 53566






Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of therapeutic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567

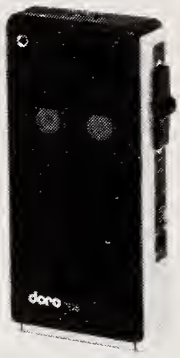
The Complete Communication Company...

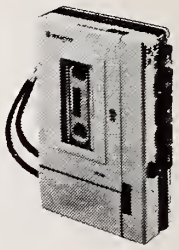
OFFICE COMMUNICATIONS INCORPORATED*

The Portables

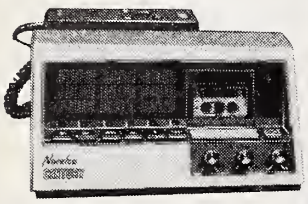

NORELCO NT-1


NORELCO 185


DORO 706

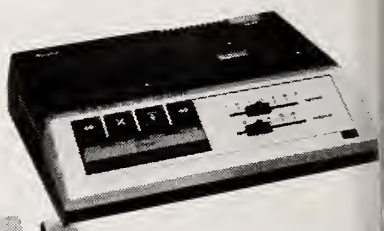

SANY 1500

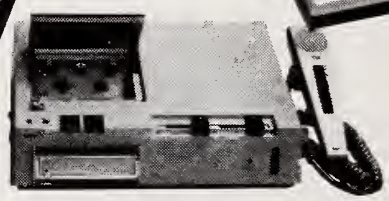
Desk Top Dictation/Transcription Systems


NORELCO CENTURY


DORO 707

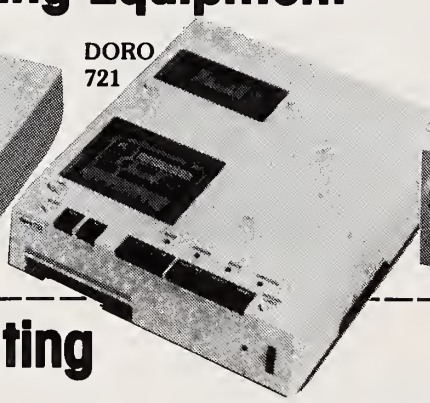

DORO 705


NORELCO 102

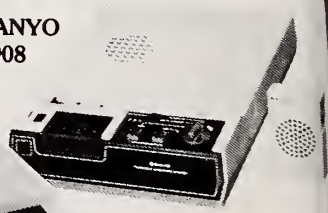

NORELCO 186

Phone Answering Equipment


SANYO 139


DORO 721


DORO 320


SANYO 9908

Telephone Dictating


NORELCO 260


DORO 732

*One Stop Communications Sales and Service...

OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry: Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service department throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED
6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741

The author discusses important medical-insurance issues, highlighting utilization review and the rate of increase in health care costs.

A Third-Party Perspective on Health Care Costs

FRED R. HIGGINBOTHAM, *Atlanta**

THANK YOU for this opportunity to address an issue that greatly concerns us all — the high cost of health care.

I want to specifically talk about the Atlanta Blue Cross and Blue Shield Utilization Review Program. I spoke to this Board on the subject in 1978, at a meeting in Rome, Georgia. This will be a follow-up of how the program has progressed since that time. Most of my remarks will address the problems we face in the metropolitan Atlanta area, so I apologize to those who are not in our Plan† area.

An Overall Perspective

Looking at the overall relationship between third party payors and the medical community, I know we have had disagreements on some specific issues. However, there is also much we argee on. Let me briefly touch on a few of these items.

Blue Cross and Blue Shield believes a working relationship with providers is the best approach to serving the public. This is reflected by the fact that members of the medical and hospital communities serve on our Board of Directors. Additionally, we do not subscribe to the theories that all hospitals are bad or doctors on Blue Shield Boards abuse the public interest.

We believe the private sector has great problem-solving abilities and should rely on these abilities rather than looking to the government for solutions. Our enthusiasm for federal intervention and legislation is well under control. We also dislike state legislation and regulation; and this may be a point of contention, since from your action to support legislation mandating certain types of benefits, it appears that you do not share those same views.

Together we have tackled major health problems before, as evidenced by these positive achievements: Life expectancy continues to increase; the death rate is at an historic low; mortality from heart disease is down 11% between 1968 and 1976; and all but 5-6% of the population now have some health insurance coverage.

These are some of the major pluses, but you will agree that the high cost of health care is still a major problem for all Americans. We must do all we can to see that costs are brought under control in Georgia.

Utilization Review Program

You will recall that on Jan. 1, 1978, Blue Cross and Blue Shield of Atlanta embarked on a controversial Utilization Review Program. We found ourselves in a situation where we were at nearly 1,000 days of hospitalization per 1,000 subscribers in 1976 (Figure 1), which put us 24% above the national average of 792 days per 1,000 subscribers. The admission rate was similarly high (Figure 2). In addition, the trend was up.

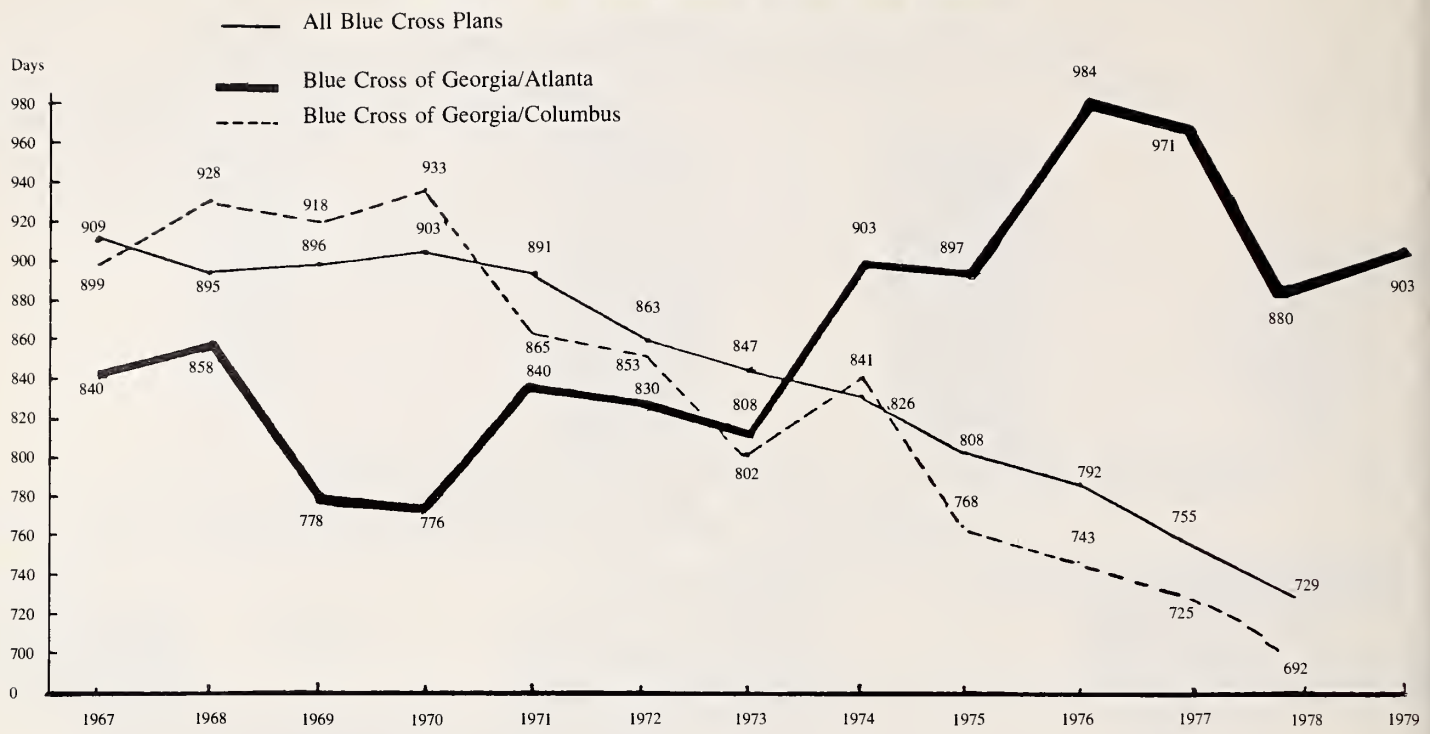
The reasons for this situation were complex. The number of doctors and hospital beds in the area was one of the key factors. Another was the public's attitude toward insurance and using the hospital.

After years of study, we received approval from our Board of Directors to pursue a program to fight this trend. We embarked on an extensive round of consultations with doctors and hospitals concerning

* The following article is based on a report given by Fred R. Higginbotham, President of Blue Cross and Blue Shield of Georgia/Atlanta, Inc., to the Medical Association of Georgia, January 5, 1980. His address is 3348 Peachtree Rd., NE, P. O. Box 4445, Atlanta, GA 30302.

† Atlanta Plan of Blue Cross and Blue Shield comprises 28 counties, including metropolitan Atlanta and northwest Georgia

FIGURE 1 — In-Patient Hospital Days per 1,000 Members*



*Excludes Medicare-Related Experience

the design of the program. We got considerable advice, some opposition, and much support, including important help from this organization. Our discussions with you and other providers had an important impact on the design of the program.

As an example, you told us to explain the program to our subscribers and encourage them to cooperate. We did. We wrote to every direct-pay subscriber; we visited every group with more than 50 members; we developed brochures for the hospital admission offices; and we asked the managers of our companies to help explain the program to employees. You gave us good advice, and we took it.

What has happened since then?

Refer to Figures 1 and 2. Note that in 1978, our days per 1,000 decreased from 971 to 880. This represents nearly a 10% decrease. By even the most conservative estimates, that decrease meant a savings of nearly eight million dollars. This decrease has gone directly to our members in the form of fewer and less frequent rate increases.

We believe this was and is an important success. Certainly, it is not ours alone, but is shared by you, the doctors, and the hospitals.

But the good news did not continue. Data for 1979 show that our days are up approximately 2.6%, to 903 days per 1,000 subscribers. The admission rate has gone from 152 to 154 per thousand. This is still a considerable improvement over 1977 but it is going in the wrong direction.

High Utilization Still a Problem

Why? We do not know. We are looking carefully at the problem. We have visited every hospital and met with utilization review committees and their chairmen to discuss it. While a few are not doing anything, most are pursuing the program. Nurse coordinators are high on it. Feedback from groups is positive. We have an action program underway to make utilization review more successful. It includes a variety of efforts to communicate with everyone involved.

Please keep in mind that this is a critical issue. This is Atlanta's main cost problem. The national average is at 729 days per 1,000 and declining. Some Plans run at 500-600 days. Some HMOs run at 400! Doctors' fees are not the critical problem, nor are hospital charges. The problem is in hospital use and in a proliferation of overbuilt, under-used institutions in metro Atlanta. Any impact here could serve the public well.

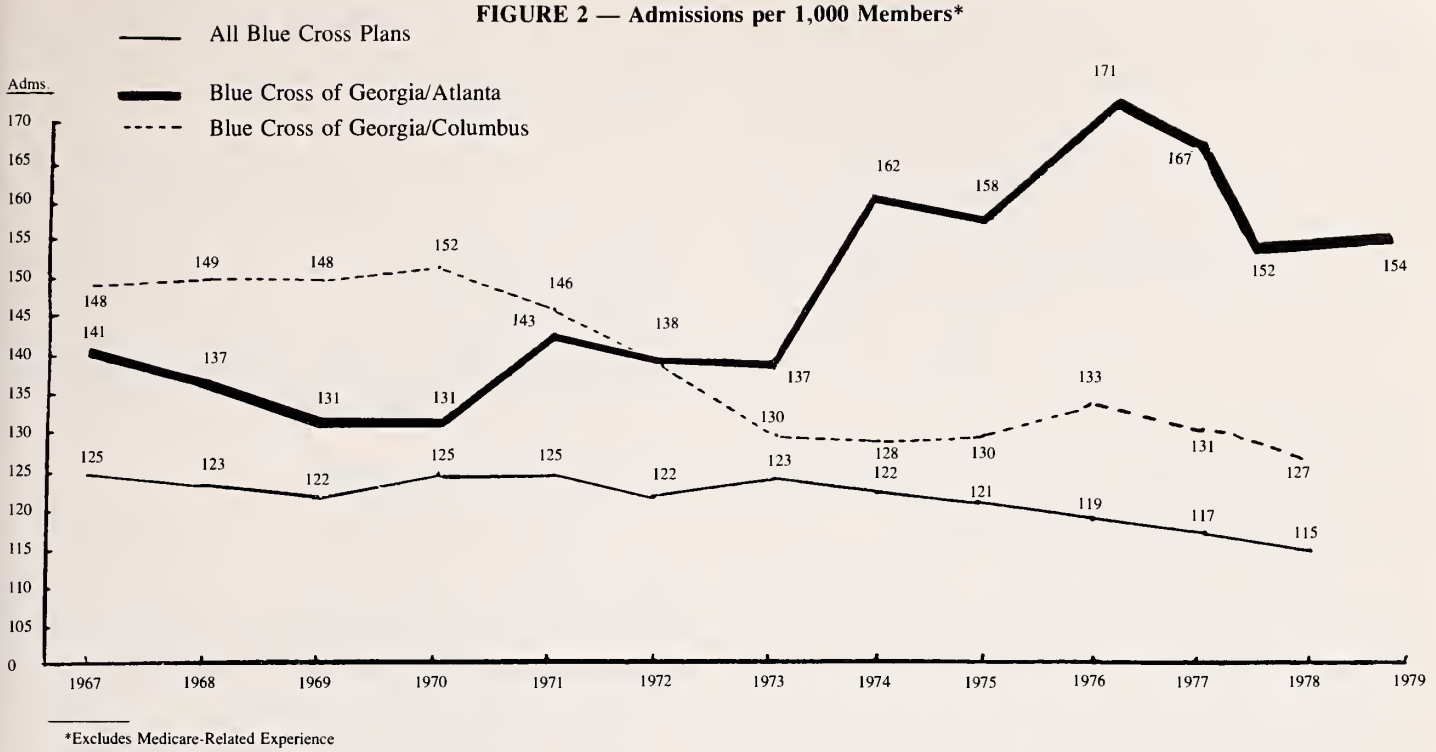
This is not just a Blue Cross problem. It is our problem together — a community problem.

I ask your continued interest and support.

At this point, one approach is to try to define the problem more carefully, more specifically, and work on "manageable bites." If we understood the various components of the problem better, perhaps we could move toward a solution to the problem as a whole.

Some of the aspects we have been looking at:

FIGURE 2 — Admissions per 1,000 Members*



*Excludes Medicare-Related Experience

Problem Hospitals — Most hospitals met the 5% waiver requirement with ease. Several hospitals had problems meeting the requirement in one or two 6-month periods, but worked on utilization and got it down.

One hospital missed the requirement for three periods, and we negotiated that it would no longer participate in Blue Cross. Two other hospitals may be in similar shape when we have figures for the latest 6 months. Our Board intends to enforce the 5% limit and will cancel their agreements if that becomes necessary.

These are positive results. The Utilization Review Program serves you and us by cleaning up marginal operators.

Specialty Review — We are trying to identify potential overuse by specialty. We looked at elective surgery as a possible area of abuse, and our data did not show any.

A few "problem doctors" have been identified and dealt with in a responsible and effective manner. The peer review mechanism has been most helpful in this regard.

We have instituted a pilot program in dentistry aimed at reducing the length of stay for oral surgery. We worked with oral surgeons to develop guidelines and preliminary information suggests this is successful.

Group Utilization — We are analyzing our enrolled population to see if subscribers' characteristics changed in ways that might cause use to move up or down.

Certain subscriber groups have very high use, and we are seeking to determine if abuse exists among those subscribers. Management and labor can help on these aspects of the problem. But Atlanta is a special problem to certain national accounts. Their rates of use are still high here in relation to the rest of the country with identical benefits and similar populations. We are encouraging them to support the program. Where we can identify group problems, we go in and work on them.

In summary, we started the Utilization Review Program to try to control hospital overuse. It worked quite well for a time. You deserve a great deal of the credit. But it is working less well now. We are trying to get it back on track. It is an intellectual, as well as an implementational, challenge to all of us. Can your PSRO or foundation or cost committee do anything? Can you bring medical expertise to bear on this problem? I urge you to consider it, to serve not just Blue Cross, but the entire public.

Other Issues

While I am here, I want to comment on a few other issues where there might be controversy. I will be frank so we can discuss these and understand each other.

Costs

To give you an update on the cost picture, I want to review some hospital and physician charge increases.

Hospital charges continue to double approximately every 5 years. In 1974, the average charge per day was $122.21; in 1979, it was $245.37. During 1977

and 1978, hospital charges increased over 13% per year. In 1979, the rate of increase was down to 11%; we hope this will continue.

In the area of physician fees, the increases are substantial. I have no overall accurate index on this, but the trends for a few procedures are illustrative. The customary charge for a D&C has increased 67% between 1974 and 1979; the price for an appendectomy has doubled; and the price for a hysterectomy is up 45%.

Legislation

As I talk, the Georgia legislature is in session, and you appear to support a couple of bills which we wish you would reconsider. They are:

Catastrophic Health Insurance — This is a perennial favorite. Many believe that if states support this, the threat of national health insurance will go away. We don't agree.

There are several problems with catastrophic health coverage. For one thing, it is very difficult to design a catastrophic benefit that applies to all — those with good, bad, or no present coverage. For another thing, catastrophic coverage tends to focus on high cost services. It will send the money into hospitals with high technological services, not primary care in rural areas.

As a priority, I think we would do well to focus on more basic coverage for those with no health care benefits. This is the problem group in our society which the private sector alone *cannot* solve.

Mandating Coverage in Doctor's Office — You are aware of some Georgia legislators' efforts on this issue. We support doing more in low cost doctors' offices and less in high cost hospitals. We have done much in this area and are willing to do more. But to mandate this or any other specific benefit is, in my opinion, the wrong approach.

Chiropractics — Even some of the most ardent critics of organized medicine have acknowledged the contributions of the physician community in opposing the use of unscientific methods in treating patients. I can only express extreme regret that during the 1980 session of the General Assembly that the Medical Association of Georgia (MAG) shifted its position on chiropractics and that all third parties will be mandated to pay chiropractors, whether they wish to or not, and to include chiropractic benefits in all contracts even though the premium payer does not wish such coverage. (News reports affirmed the importance of the MAG position, and at least one chiropractor was quoted as looking forward to further cooperation with physicians.)

Foundation-PSRO

We have worked with and been supportive of your evolving PSRO effort and are aware of funding and other problems.

Health Education

I am pleased that you are are involved this year with the Health Fair sponsored by WSB-TV, Blue Cross and Blue Shield, and the Red Cross. There is a revolution taking place in public attitudes about health and fitness. We will continue to support you as you promote good diet, exercise, no smoking, etc. We all need to be interested in the healthy population, as well as the sick.

Admission Battery Testing

At your annual meeting last April, you approved a policy stating that a physician should specifically order all tests on hospital patients in order to avoid unnecessary costly tests. Blue Cross and Blue Shield organizations pioneered this approach and your support has been helpful.

We are working with our hospitals and encouraging them to review their policies with the medical staff. A number have changed their policies, eliminating such things as routine chest X-rays, SMA-12s, and other items. Most now require just a CBC and urine, or have no mandatory routine tests at all.

Health Maintenance Organizations (HMOs)

We are considering an important initiative here. If we go into it, we will do so on a private basis and try to avoid federal strings. Our thinking is that HMOs are not a panacea and will likely have only a small share of the market in the next 10 to 20 years. But they will be here. We believe HMOs will be good for some hospitals, some doctors, and some patients.

Voluntary Effort (VE)

The Georgia VE has been helpful. Can we do more? I would genuinely like to see hospitals, doctors, and third parties sit down together to work on common problems. While we may disagree on specifics, we have much in common. Most of us want a high quality delivery system of good hospitals and doctors, and we believe they should be well financed, not financially starved. The public generally feels the same way and would be willing, even pleased, to pay the price — if only we can slow the rate at which that price increases.

This year, for the first time, inflation in the health care market is less than that of the economy as a whole — that includes the Consumer Price Index, housing, energy, and other factors. This is good, but our rate of increase is still quite high. We look good only because the rest of the economy is having such severe problems.

I believe the legislative defeat of cost caps gives us

only a temporary reprieve. We should not relax.

I appreciate the opportunity to speak with you here and share my views. You will be amazed that I am not after anything other than to thank you for your support, to let you know our thinking and to get your comments, reactions, and suggestions so that, working together, we can better serve the people of our state.

Clinical Note: Brucellosis

G. ANDREW SENDELBACH, B.S., KENNETH ALONSON, M.D., F.A.C.P., RAYMUNDO MALLARI, M.D., G. R. FOSTER JR., M.D., *Stockbridge

THE INCIDENCE of brucellosis has declined in recent decades, from more than 6,000 cases in 1947[1] to fewer than 200 cases in 1978.[2] In the United States, the disease is spread primarily through contact with infected meat. Brucella is largely overlooked as a cause of disease because its clinical manifestations are nonspecific, associated with a wide variety of infections, and often insidious in onset.[3] Furthermore, the disease is normally self-limiting,[1] and bed rest usually brings prompt improvement and a spontaneous recovery. Nevertheless, brucellosis is still a public health problem.

Case Report

A 26-year-old white man had onset of a mild fever (99°F) and lower back pain, and was treated with salicylates for 2 weeks. Subsequently he was admitted to Henry General Hospital with a fever of 102-103°F, which subsided after the patient had had some bed rest. Extensive studies of blood, urine, and stool specimens were unremarkable. Extensive radiographic examinations were also unremarkable. Febrile agglutination tests revealed a *Brucella abortus* titer greater than 1:320. On the 10th day, cultures of blood specimens were positive for a gram negative coccobacillus. The organism was aerobic, catalase positive, urea positive, and produced H_2S. It was identified as *B. suis*. The patient was discharged from the hospital and placed on a 4-week course of tetracycline therapy.

Careful questioning of the patient revealed that he worked as a refrigeration mechanic in the metropolitan Atlanta area. He worked principally with meat lockers and was often exposed to raw meat products.

The importance of taking a careful history and the use of proper methods and procedures in the laboratory cannot be overemphasized. The Brucella agglutination test using standardized antigen is the most rapid means of diagnosis. A recent review confirms that a titer greater than 1:100 indicates active disease.[4]

The agglutination test cross-reacts with all species of Brucella (except *B. canis*), *Yersinia enterocolitica, Francisella tularensis,* and *Vibrio cholerae*. Such a growth in a culture confirms the diagnosis.

When brucellosis is suspected or there is a positive Brucella titer, effective treatment should be initiated and proper follow-up continued.

* Mr. Sendelbach and Drs. Alonso, Mallari, and Foster are from Henry General Hospital in Stockbridge. Address reprint requests to Dr. Alonso at 1133 Hudson Bridge Rd., Stockbridge, GA 30281.

References

1. Spink WW. *The Nature of Brucellosis*. Minneapolis: University of Minnesota Press, 1956.

2. *Brucellosis,* 1978 Annual Summary, Center for Disease Control (1979).

3. Suvannoparat U, Young EJ. Brucellosis outbreak attributed to ingestion of unpasteurized goat cheese. Arch Intern Med 1975;135:240-243.

4. Liu PI, McHone JS, Ackerman NB, Glassman AB. Brucellosis: A continuing problem. JMAG 1976;65:445-448.

Peachford Hospita
A uniquely positive, comprehensi

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge. Twenty-four hour admittance is offered for all programs.





MEDICAL SERVICE DIRECTORS

BOAZ HARRIS, M.D.
Medical Director

CONWAY HUNTER, JR., M.D.
Director, Addictive Disease Unit

CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

JOHN B. HARDMAN, M.D.
Director, Children's Unit

rogram of recovery...that's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

omplete information or a personal tour of the facilities and explanation of programs, contact:

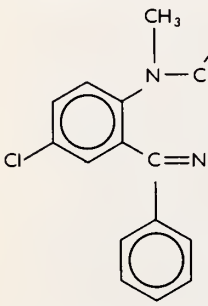
PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30338
Phone (404) 455-3200



Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche)

Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.* Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy. Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.



What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics,



barbitu-
rates, MAO
inhibitors and
other antidepres-
sants may potentiate
its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

2-mg, 5-mg, 10-mg scored tablets

Valium® (IV)

diazepam/Roche

An important adjunct to your treatment program for excessive psychic tension

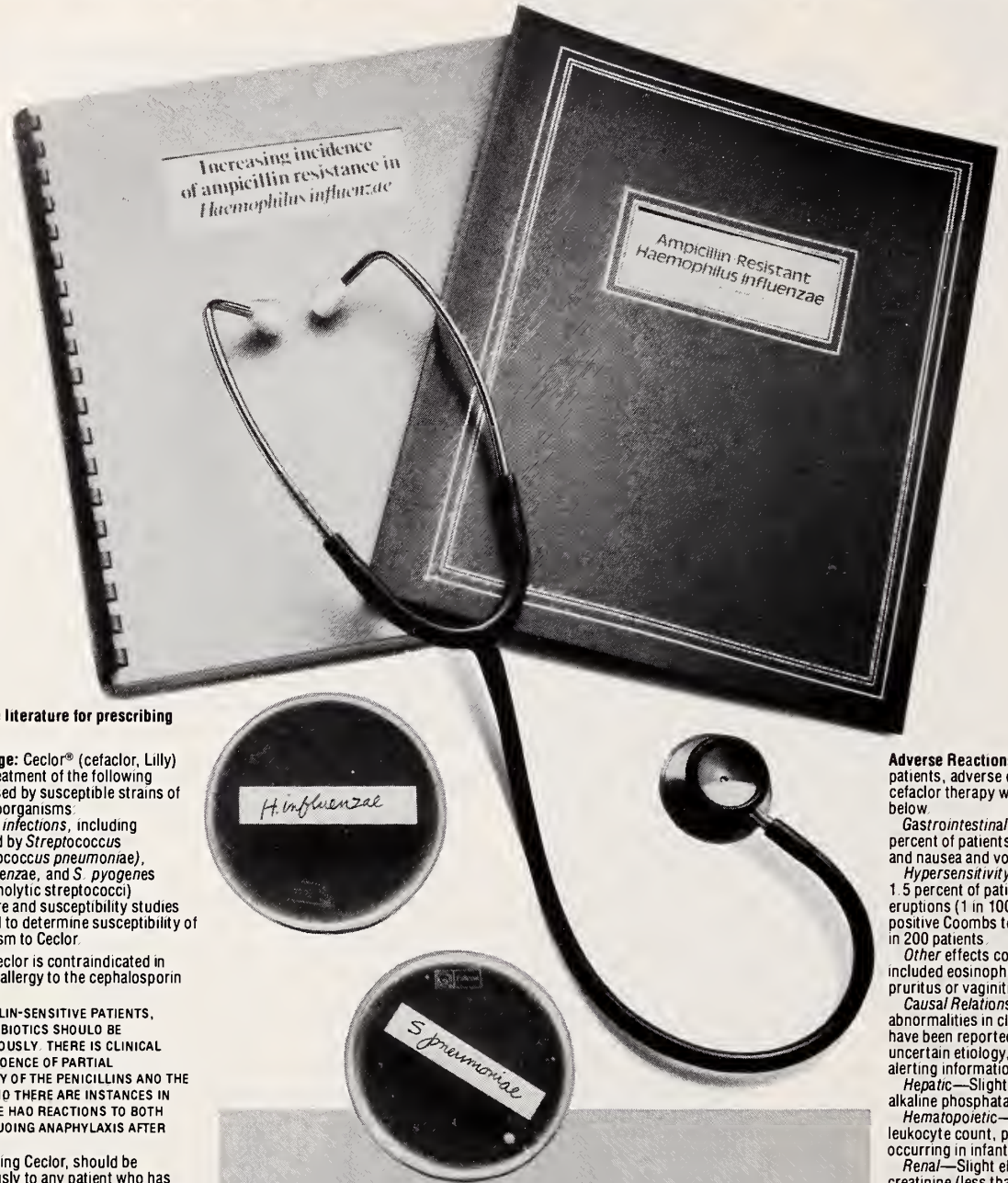
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

ROCHE®

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note. Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Lilly

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

000482

The authors describe the MEDLARS information system and detail one hospital's initial experience in joining the system.

Computerized Literature Search in the Community Hospital

CYNTHIA N. TIMM, M.L.S., MARK E. SILVERMAN, M.D., and NICHOLAS E. DAVIES, M.D., *Atlanta**

To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.

William Osler, "Books and Men" in Aequanimatas, With Other Addresses

Introduction

In 1901, when William Osler spoke these words to a gathering at the Boston Medical Library, the well-intended physician had little trouble staying current with the literature, for only a few medical textbooks and journals were available. Since articles were mostly short and descriptive in format, the physician did not have to contend with complex methods of study, was not overwhelmed by the statistical significance of the matter under discussion, and was not troubled by self-assessment questions lurking in some future re-certification examination. Today, however, textbooks are thick, journals are plentiful, and articles are complex and time consuming. Adrift in an uncharted sea of literature, the physician may not know how to find the small island of information that will solve the clinical problem. Fortunately, MEDLARS, the National Library of Medicine's Medical Literature Analysis and Retrieval System, has come to the rescue by offering computerized literature searches that can swiftly and accurately locate key articles in the medical literature. MEDLARS is now available to community hospitals, and this article is intended to detail our initial experience with this information system to other interested community hospitals.

One Hospital's Experience

In 1974, Piedmont Hospital built an addition that linked the hospital to a new professional office building. This new space provided an opportunity to incorporate a library that would be immediately accessible to the physicians. Although a medical library had been available, it was physically apart from the hospital and rarely used by the physicians. The new library was adequately staffed with a full-time librarian, an assistant librarian, and part-time help so that the library could be open from 8:30 a.m. to 9:00 p.m., Monday through Thursday, and Sunday evening. A key located nearby allowed entry at other times. Books and journals were added to the existing collections, and an audiovisual room capable of receiving broadcasts from the Department of Medicine of Emory University at Grady Memorial Hospital was provided. The new facility proved to be a boon for physician, nursing, and patient education, reaching out to provide educational services throughout the hospital. In 1977, concerned with the expanding use of the library and the need for better and faster information retrieval, the library committee studied the feasibility of joining MEDLARS. At that time the librarian was spending an average of 90 minutes per search, using generally available indexes. The MEDLARS system offered a log of approximately 4,500,000 references that could be scanned and transmitted in 10-15 minutes. In addi-

* Ms. Timm is the medical librarian at Piedmont Hospital; Dr. Silverman is Professor of Medicine (Cardiology) at Emory University School of Medicine; and Dr. Davies is Clinical Associate Professor of Medicine, Emory University School of Medicine, Atlanta, Georgia. Address reprint requests to Dr. Silverman at 1968 Peachtree Rd., NW, Atlanta, GA 30309.

tion, the system could provide more accurate information than the indexes because it could combine a variety of subject headings and key words and limit the search to specified age groups, time periods, languages, etc. The system is also updated frequently and contains citations in medicine, nursing, health care administration, toxicology, cancer research, and audiovisual programs (AVLINC).

Initial Preparation

A questionnaire was distributed to members of the hospital staff to determine their interest and attitudes toward computerized reference services. The majority indicated that they were unfamiliar with the specifics of the MEDLARS system but that they would like this capability to be available at Piedmont Hospital. Several people had requested searches through Emory University but had found this to be inconvenient and costly. The library committee then consulted the Southeastern Regional Medical Library at Emory for specific information concerning computer terminals, on-line charges, and personnel training requirements. Initial starting charges included $150.00 for computer manuals and training at Emory and $2,000.00 for a dial-access terminal. The committee recommended to the hospital administration that a contract with MEDLARS be signed, and in April, 1978, Piedmont Hospital became the first community hospital in Georgia offering computerized literature searches. An extensive publicity campaign was conducted to encourage hospital staff to utilize the new computer service. The librarian demonstrated the computer's capabilities at various conferences and distributed written announcements to the staff. Hospital departments were given an unlimited number of searches, while physicians were given a quota of free searches with a fee of $2.50 per search thereafter.

MEDLARS provides a more dynamic interaction between the physician and library, with the end result being improved patient care.

Results

The library has now been performing computer searches for almost 2 years, with generally favorable results. An average of 20 requests are received each month. The majority come from physicians; however, nurses, respiratory therapists, dietitians, and laboratory personnel also use the system frequently. While the computer has not greatly increased the library's total number of referred reference questions, the requests have become more specific and cover a wider variety of topics. A great advantage of the system is that the requester can receive immediate feedback in the form of a printed list of citations. The amount of time saved in searching has justified the average monthly on-line charge of $50.00.

Problems

Although users of MEDLARS have generally been pleased with the results, some problems have arisen. The most frequent criticism is that MEDLINE, the primary data base, contains on-line citations for only the past 3 years, while many requesters would prefer immediate access to 5 or more years of the literature. The system is disease-oriented and appears to contain little information related to normal, healthy individuals. Nursing and other allied health fields are poorly represented in the data bases. The computer does not effectively solve the clinician's immediate problems (for example: determining whether patients with procainamide-induced lupus can get hemolytic anemia) and has been more useful for research projects or preparing lectures. Approximately 40% of the references appearing on the computer print-outs have not been in our library collection. They have been available through interlibrary loan; however, there is time and expense involved in processing the loans. Another problem with MEDLARS has been the complexity of the system itself and the extensive training required for the librarian.

In spite of these difficulties, Piedmont Hospital has found the MEDLARS computer system to be a definite asset to our community hospital. Although the volume of searches may be lower than that in a research institution, the computer does provide the practicing physician and health professional with rapid access to medical information.

Future Plans

The library plans to increase the number of computer searches through greater publicity and more demonstrations. Computer-generated bibliographies on topics of interest will be kept on file in the library and made available to the staff. Free searches may be offered to physicians who are planning continuing education conferences, and computer demonstrations may be given at various hospital department meetings. In the future, we anticipate that the system will provide a more dynamic interaction between the physician and library, allowing access to specific information that will improve patient care.

editorial
editorial
editorial

The Paradox of Pharmaceutical Advertising

IT MUST BE OBVIOUS to most of our readers that the editorial content of the *Journal* has been reduced considerably in the past few years. This cutback in the size of our publication has not been dictated by a lack of available desirable material for publication, but by a marked reduction in our volume of advertising from the ethical pharmaceutical manufacturers. All state medical journals and many other scientific publications have suffered this cutback and have had to reduce their size accordingly. Yet we have noted an almost explosive growth of mass circulation, abstract types of publication. One look at these publications will confirm the fact that their growth is solidly underwritten by ethical drug advertising. It is ironic that the sources of much of the material published by these profit-inspired publications are being endangered by these reductions in advertising volume in the scientific journals.

Statistics may prove that because of the mass unpaid circulation of these abstract-type publications, the advertising dollar of the manufacturer goes farther than in the scientific journals which provide the original material. From a physician's point of view, this concept of the parasite ultimately consuming its host because of a "convincing advertising salesman's pitch" is basically unsound. Nevertheless, this paradox seems to make sense to the advertising executives who make their decisions.

We are all aware that the great majority of our scientific publications were begun and are maintained as the official organ of physicians' associations. These journals are oriented toward basic scientific investigation or toward the clinical practice of medicine. The long-time survival and growth of these publications provide eloquent evidence of their readership and influence with their readers. The fact that physicians pay money year after year for the privilege of receiving these journals suggests good evidence of their acceptance and readership. Such journals have an editorial policy which reflects the basic interests and standards of their sponsoring organizations. Because of this, these publications command the respect and interest of the physician who ultimately prescribes the products promoted by the ethical pharmaceutical manufacturers.

With such a set of circumstances as outlined above, it becomes our obligation as physicians to be more aware of the role that has been so actively taken by the ethical drug firms in the support of our publication. If these firms are continuing to favor our *Journal* with their advertising message, their representatives who call upon us in our offices should be made aware of our appreciation. If a detail man's firm is not advertising in our *Journal,* a few gentle reminders to him will ultimately be transmitted to his company officials. Our visits to exhibit booths sponsored by pharmaceutical manufacturers at scientific meetings will go far toward making these companies aware of our interest and continuing support of their ethical products. It is up to us to voice our support of their support. This is part of our obligation as physicians towards better communication — this time not with patients but with those who provide their medicines.

Edgar Woody Jr., M.D.

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, IN
MARIETTA, GEORGIA

AIR ONE



SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

CHOPPER ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

MICO 101



PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO

AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

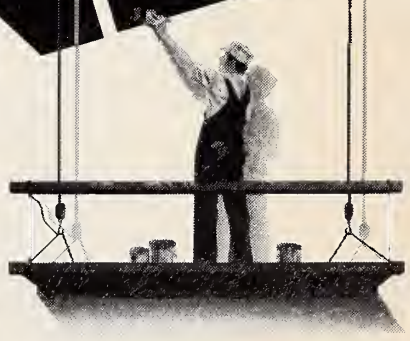
CALL TOLL FREE

GEORGIA 1-800-282-7984

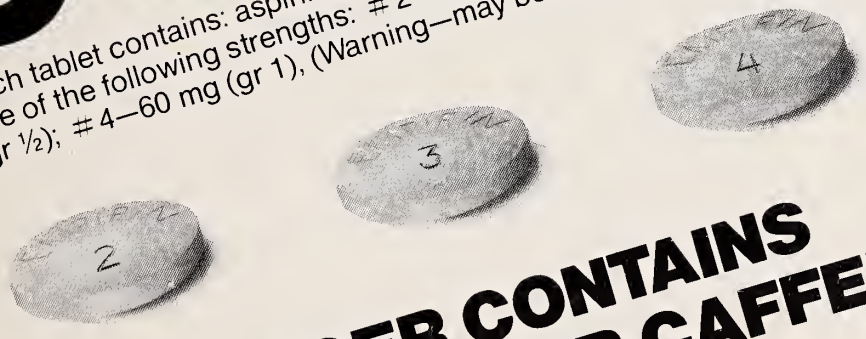
NATIONWIDE 1-800-241-77

~~EMPIRIN®~~
~~COMPOUND~~
~~CODEINE~~
IS NOW

EMPIRIN® CODEINE



Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg (gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)



NO LONGER CONTAINS PHENACETIN OR CAFFEINE.

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

Copyright © 1980 by Merck & Co., Inc

by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia), and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

From this study it would appear that the change in the new law has not significantly affected the number of patients admitted by the involuntary petition process.

Report of Some of the Effects of Georgia's New Civil Commitment Law on Patients in a Private Psychiatric Hospital

DAVE M. DAVIS, M.D., *Atlanta**

Introduction

GEORGIA'S NEW CODE governing the hospitalization and treatment of mentally ill persons became effective September 1, 1978. In addition to addressing numerous procedural issues, Georgia Code 88-5 strengthened the civil rights and liberties of patients confined to mental hospitals. At the same time, this new law narrowed the standards for civil commitment to mental hospitals. Under the new code, the standards for emergency hospitalization, evaluation, and treatment are as follows:

> A mentally ill person requiring involuntary hospitalization means a person who is mentally ill and (a) who presents a substantial risk of imminent harm to himself or others as manifested by either recent overt acts, or recent expressed threats of violent behavior which presents a probability of physical injury to himself or to other persons, or (b) who is so unable to care for his own physical health and safety as to create an imminently endangering crisis.†

At the time the various drafts of this law were being discussed, many speculated that narrowing standards would substantially affect involuntary hospital procedures at Georgia's mental hospitals. This is a report of the effects of that revised code at one private psychiatric hospital in the Atlanta area.

Effects of the Revised Code

Table 1 shows a comparison in the 4-month period before and after the new law was put into effect. Unfortunately, data were available only for one 4-month period prior to the law's becoming effective. In this 4-month period prior to the effective date of the new law, 8.5% of all patients admitted were in some way involved with an involuntary petition for admission. One of two situations existed: (1) either a patient was brought to the hospital under the authority of Form 1013 signed by a physician, or (2) a person was admitted to the hospital voluntarily, but later had an involuntary petition signed, probably at a time he wanted to leave the hospital.

Following the implementation of the law in September, 1978, the number of patients involved in involuntary petitions remained essentially unchanged. During each of the three 4-month segments reported on, the monthly incidence of involuntary petitions was 15.3%, 7.8%, and 14.0%, for an average of 12.3%. Of the 86 patients who were in some way involved in the petition process, 75 (87.2%) eventually signed a request for transfer to voluntary status. Nine (10.5%) refused to sign such a transfer to voluntary status and requested a court hearing. In all cases, the commitment was upheld by the court.

Table 2 presents the diagnoses, taken from the petition form recorded by the attending physician.

* Dr. Davis practices psychiatry at Peachtree and Parkwood Mental Health Center and Hospitals. His address is 1999 Cliff Valley Way, NE, Atlanta, GA 30329.

† Georgia Code 88-501.

TABLE 1 — Comparison of Hospitalization Rates Before and After Georgia's New Code

Time Period	Total Admissions	Total Petitions	Involuntary Admissions By Petition	% of Total Admissions With Petition	Involuntary Petitions on Voluntary Admissions	Transferred to Voluntary Status After Admission via Petition	Transferred to Another Hospital	Suicide	Court Hearing	Committed Involuntarily by Court
May 1-August 31, 1978	259	22	Not Available	8.5	Not Available	Not Available	Not Available	0	Not Available	Not Available
September 1-December 31, 1978	229	35	19	15.3	16	32	1	0	5	5
January 1-April 30, 1979	244	19	13	7.8	6	15	3	1	3	3
May 1-August 31, 1979	229	32	21	14.0	11	28	3	0	1	1
TOTALS: September 1, 1978-August 31, 1979	702	86	53	12.3	33	75	7	1	9	9

TABLE 2 — Diagnosis* of Illness in Patients on Whom Petitions Were Filed

Diagnosis	Number
Paranoid	27
Suicidal, Depressed	25
Schizophrenia	18
Alcohol or drug dependent	5
Alzheimer's organic brain syndrome	5
Manic depressive	2
Mental retardation	1
Psychotic	1
Anxiety neurosis	1
Personality disorder	1

* Taken from the petition form, not the medical record.

Medical records revealed that most of the patients were diagnosed as paranoid, and some of those diagnosed as schizophrenic were felt to be dangerous to others. Those felt to be dangerous to themselves were usually diagnosed as depressed, suicidal, or in some cases, schizophrenic.

Discussion and Conclusions

Unfortunately, only minimal comparative data are available from records prior to implementation of the new code. Confidentiality of court data made it virtually impossible to retrieve previous data. However, this survey seems to indicate that the change in the new law did not significantly affect the number of patients admitted by the involuntary petition process in a private psychiatric hospital. Overall, 12.3% of all patients admitted to the hospital were involved in the involuntary petition process. Among such individuals, 87.2% requested a transfer to voluntary status prior to discharge. Only 1.3% (9 out of 72) of all patients admitted actually had a court hearing. All of those so doing were involuntarily committed.

From these data, it does appear that the attending physicians and hospital staff made a concerted effort to encourage patients to transfer from involuntary to voluntary status. Many patients appeared to improve psychiatrically during the time between admission and when they would have had a court hearing. This probably contributed to their willingness to transfer to voluntary status. Furthermore, it appeared that only those cases were taken for a hearing where the chances of danger to self or others were clear-cut. This is reflected in the 100% commitment rate from the court.

The data also indicate that the most frequent diagnostic categories involved in involuntary hospitalization are schizophrenia, particularly paranoid type, and depression of suicidal proportions. The involuntary commitment procedure seemed to be rarely used in the case of addictions related to alcohol or drugs, or in the case of individuals so unable to care for their own physical health and safety as to create an imminently endangering crisis.

What To Do and Not To Do In the Emergency Treatment of Mentally Ill Persons

ROBERT N. BERG, *Atlanta**

You are staffing the emergency room of a hospital designated by the state as an "emergency receiving facility" for the treatment of mentally ill persons[1] when you receive a call from a distressed woman. She tells you that her husband has gone insane, that he is running around their house naked, and yelping like a coyote. She also says that, while her husband has not made any threatening gestures toward her, she is nevertheless afraid because he owns a 12-gauge shotgun. In addition, she tells you that her husband, in a sanguine moment between fits of rage, told her very calmly that he was going to "take care of" several of their noisy neighbors by blowing up their houses. The woman then pleads with you to order that her husband be committed for emergency treatment.

Can you comply with the caller's request and order that her husband be committed for treatment? If you do, what is your potential liability if it turns out that her husband was sane and that the woman was actually the one who was mentally ill? Conversely, what is your potential liability should you refuse to order that the husband be committed, and he subsequently commits suicide, injures a neighbor, or destroys a neighbor's property? Short of ordering that the husband be committed, what can you do, and what can you advise the panic-stricken caller to do?

What You Can't Do

The first thing you should be aware of is that the procedures by which a person may be involuntarily committed to an emergency receiving facility are strictly governed by statute. The *only* time in which you are authorized to order that a person be taken into custody and brought to an emergency receiving facility for treatment is when you have *personally examined* that person within the preceding 48 hours and, based upon that examination, you are of the opinion that the person both (1) appears to be mentally ill and (2) either (a) appears to present a substantial risk of imminent harm to himself or others as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself or to other persons, or (b) appears to be so unable to care for his own physical health and safety as to create an imminent life-endangering crisis.[2]

Accordingly, your first response to the distressed caller should be to ask whether she can bring her husband in so that you can examine him. If she does so, and if you do personally examine him and make the determinations described above, then your next step would be to fill out a Form 1013 "Emergency Admission — Physician's Certificate" issued by the Georgia Department of Human Resources. The Form

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

1013 would then be given to a peace officer, in most cases either from the local police department or local sheriff's office, who is authorized by statute to make diligent efforts to take the person named in the form into custody within 72 hours after receiving the form and to transport that person to the emergency receiving facility for treatment.[3]

If, as in this example, the woman says she is unable to bring her husband to the emergency room for you to personally examine him, your next option is to ask if he has been examined by a physician within the last 48 hours. If he has, then you could advise her to contact the examining physician and have him certify as to the matters described on the Form 1013.

What You Can Do

The result of your not having personally examined the husband within the last 48 hours is that you cannot participate in the emergency commitment process to the extent of ordering that the husband be brought in for emergency treatment. Nevertheless, there are several alternatives with which you should be familiar and which you can advise the caller about.

Initially, a peace officer is authorized to take a person to a physician for emergency examination by the physician or directly to an emergency receiving facility for treatment, if that person is committing a penal offense and the police officer has probable cause for believing that the person is a mentally ill person requiring involuntary treatment. As to the second of these conditions, the peace officer need not formally tender charges against the person prior to taking him or her to a physician or to an emergency receiving facility.[4]

Thus, in this case, you can advise the distressed woman that her best option might be to contact the local law enforcement agency in her area if she believes that her husband is about to commit a penal offense. In addition, if the husband is not actually committing a penal offense at the present time, but if it is feared that he will do so in the future, you could apprise the woman of the fact that most counties have "crisis intervention units" specially trained in dealing with situations of this type. Thus, you might suggest that she contact her local crisis intervention unit.

As another alternative, you should also be aware of the provisions of the Georgia Code whereby two persons familiar with a person believed to be mentally ill can execute an Affidavit to the effect that they have reason to believe that, based upon their personal observations within the preceding 48 hours, a person is mentally ill and requires involuntary treatment. This Affidavit, which is filed with the judge of the county probate court, requires that affiants certify that the person thought to be mentally ill either (1) presents a substantial risk of imminent harm to himself or others as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself or to other persons, or (2) is so unable to care for his or her personal health and safety as to create an imminently life-endangering crisis.[5]

Based upon this Affidavit, the probate court judge can issue an order directing a county peace officer to apprehend the person named in the Affidavit and take him to a designated emergency receiving facility for examination and treatment by a physician.

Potential Liability

If you have acted in good faith and have followed the "dos and don'ts" set out in this article, your potential liability is minimal.

Thus, if you respond to the distressed caller's request that you order her husband committed for emergency treatment by saying that you cannot do so because you have not personally examined him within the past 48 hours, you are protected from liability. Pursuant to *Ga. Code Ann.* §88-502.23, any physician who acts in good faith in compliance with the admission and discharge provisions of the Georgia Code shall be immune from civil or criminal liability for his actions. Consequently, if the husband in this hypothetical situation were to injure his neighbor or to destroy his

neighbor's property, the neighbor could not successfully assert a cause of action against you. By the same token, if you had personally examined the husband within the previous 48 hours, and, on the basis of that examination, certified that the requirements set forth in the Form 1013 had been met, the statutory immunity granted under the Georgia Code would protect you against liability to the extent that you had acted in good faith.

On the other hand, if the husband were in fact not mentally ill and you knew this and nevertheless acted so as to cause him to be involuntarily committed, you may be potentially criminally liable under the Criminal Code of Georgia, which provides that a person who maliciously causes the confinement of a sane person, knowing such person to be sane, in any asylum, public or private, shall upon conviction be punished by imprisonment for not less than 1 nor more than 10 years.[6]

Notes

1. An "emergency receiving facility" is a state-owned or state-operated hospital, community mental health center, or other facility utilized for the diagnosis, care, treatment, or hospitalization of mentally ill persons, which has been designated by the state to receive patients under emergency conditions in accordance with *Ga. Code Ann.* §§88-504.1 through 88-504.6. *Ga. Code Ann.* §88-501(1).
2. *Ga. Code Ann.* §88-504.2(a).
3. *Ga. Code Ann.* §88-504.2(b).
4. *Ga. Code Ann.* §88-504.3.
5. *Ga. Code Ann.* §88-504.2(b).
6. *Ga. Code Ann.* §26-1310.

Introducing...

TEGA-CORT FORTÉ 1% - TEGA - CORT - 0.5%

(Available at all drug stores - Rx Only)

SQUEEZE TYPE DISPENSER BOTTLES

Tega-Cort Forté and **Tega-Cort** lotions are offered in a nice smooth non-staining water soluble base.

Indications: For relief of the inflammatory manifestations of corticosteroiid responsive dermatoses including Poison Ivy, and sunburn.

Contraindications: Topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, or in large amounts, or for prolonged periods of time.

Dosage and Administration: Apply to affected area 3 or 4 times daily as directed by your physician.

Caution: Federal law prohibits dispensing without prescription. For external use only. Store in a cool place but do not freeze.

PLEASE CONSULT INSERT SUPPLIED WITH EACH BOTTLE FOR MORE DETAILED INFORMATION

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from December through February 1980.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Mohammad A. Al-Baghal, Savannah
Rafael A. Alvarez, Milledgeville
Ursula Mary Anderson, Marietta
Ann Anderson Bailey, Warm Springs
Madhukar S. Bandisode, Augusta
Bruce Harlan Becker, Atlanta
Bernard A. Bergman, Smyrna
Henry Aimar Brandt, Savannah
Elbert Harry Brown, Warner Robins
Russell Earle Burgess, Fort Gordon
Glyn Gordon Caldwell, Atlanta
Gerald Eugene Caplan, Savannah
Thomas H. Cartwright, Tucker
Robert Caldwell Christmas, Marietta
Sheldon B. Cohen, Atlanta
Rudolf Albert Colmers, Savannah
Roberta Lee Conrad, Atlanta
Ina Sylvia Crawley, Decatur
Dave McAlister Davis, Atlanta
James Watson R. Davis, Columbus
Robert E. DeLashmutt, Atlanta
Jordan V. Dinolov, Ashburn
Alonzo Nelson Diodene, Augusta
William Asa Dodd, Wrightsville
John Thomas DuPree, Dublin
Julius Ehik, Smyrna
Gary Thomas England, Atlanta
Ilhan Ermutlu, Decatur
Ellis Wayne Evans, Macon
Richardson Emerson Felder, Atlanta
Darius Flinchum, Atlanta
Thomas V. Foster, Columbus
John Edward Fowler, Clayton
Paul Bailey Francis, Decatur
Jackson T. Giles, Newman
Amnon Gimpel, Atlanta
Clark Howell Glass, Marietta
James Thomas Goodrich, Atlanta
Henry Andrew Hansen, Atlanta
William Kenneth Harper, Columbus
Kathie Jean Harrison, Athens
Steven John Harwood, Augusta
James Robert Hattaway, Albany
Darvin L. Hege, Atlanta
Alan Richard Hinman, Decatur
Raymond Chihta Ho, Americus
Jeff J. Holloman, Savannah
James Dixon Hull, Douglasville
Jane Blakely Jennings, Savannah
Edwin Ladd Jones, Atlanta
Kenneth Douglas Jones, Augusta
Henry Jerrold Kaplan, Atlanta
John Thomas King, Thomasville
Allan Jay Korsower, Atlanta
J. Moultrie Lee, Savannah
John Ridley Lovvorn, Rome
James Edward Marlow, Dalton
Alfonso Marmolejo, Atlanta
James Bledsoe Martin, Albany
Miles Herbert Mason, Duluth
Stephen Cuthbert May, Kennesaw
Edwin Aylette Mayo, Brunswick
Marjorie B. McSweeney, Atlanta
Jason Lawrence Meadors, Valdosta
Theodore John Mellinger, Augusta
Harold David Meltzer, East Point
Ronald M. Milestone, Smyrna
Philip E. Morgan, Norcross
Shajih Lutfi Muhanna, Riverdale
George Richmond Mushet, Augusta
Feliciano Calma Nora, Rome
Clark Lamont Osteen, Savannah
Robert Eugene Parham, Marietta
Richard C. Parsons, Decatur
E. Mansell Pattison, Augusta
Alan Stephen Peiken, Columbus
Mila Petkovich, Savannah
Peter George Petrou, West Point
Bobby Lamar Pilcher, Warner Robins
Frank Smith Pittman, Atlanta
Adolfo Ponce DeLeon, Atlanta
Mac Willys Porter, Atlanta
Lorenzo Del Portillo, Hardwick
Jack A. Raines, Columbus
Fred M. Rankin, Macon
Patnana Syamasundar Rao, Augusta
Kalathoor P. Reddy, Vidalia
Sudhakara M. Reddy, Statesboro
Jacinto Regalado, Hardwick
Charles T. Reveley, Fort Stewart
Marlan LeVan Rhame, Decatur
Wells Riley, Jonesboro
Richard Spector Robbins, Columbus
Michael H. Roberts, Albany
Fernando Rodriquez, North Decatur
Francisco R. Rodriguez, Carrollton
Harry E. Rollings, Savannah
Ronald Phillip Roper, Marietta
Ralph Emerson Roughton, Atlanta
David Morgan Rowland, Decatur
Robert Alexander Sears, Macon
Kailash Behari Sharma, Augusta
William Gains Slaughter, Thomasville
Randolph Relihan Smith, Augusta
Robley D. Smith, Tifton
Stuart Austin Smith, Rome
Dixie E. Snider, Tucker
Oved Soffer, Atlanta
Peter Chris Sotus, Decatur
Luther David Stacy, Atlanta
J. Benham Stewart, Macon
Olan Wytch Stubbs, Tucker
C. Downing Tait, Atlanta
Corbett H. Thigpen, Augusta
William Albert Threlkeld, Valdosta
William Lee Tift, Macon
J. Clarence Trice, Athens
Truman Louis Vasko, Vienna
Jesse William Veatch, Atlanta
Minor Charles Vernon, Macon
John Louis Waller, Atlanta
Lawrence L. Washburn, Atlanta
David Thomas Watson, Atlanta
Benjamin Charles Wills, Savannah
William Adolphus Wood, Atlanta
Edward Dale Wysong, Hartwell
Raymond Arthur Young, Rome

TALK IS CHEAP

in the *Journal*'s Classifieds

Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The ***Journal*'s Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.

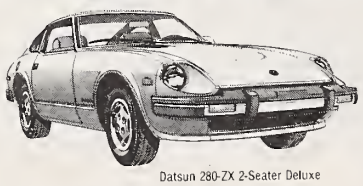
DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

HICKMAN DATSUN
ATLANTA HEADQUARTERS
5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,
Anne & Harry Friedman
Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® C(IV)

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa. 19101

heart page
heart page
heart page

Potassium-Rich Foods — Do They Do the Hypertensive Patient Any Good?

S. HEYDEN, M.D., *North Carolina**, *and* C. G. HAMES, M.D., *Georgia**, *and* I. TALTON, M.D., *North Carolina**

May is National High Blood Pressure month. The High Blood Pressure Committee of the Georgia Affiliate of the American Heart Association is featuring this article as a special observance of High Blood Pressure month in Georgia.

Introduction

In 1979, the National Academy of Sciences in Washington, D.C., reiterated the common recommendation to utilize potassium-rich foods for hypertensive patients who experience hypokalemia:

> "As is true of thiazide diuretics, furosemide and ethacrynic acid increase potassium excretion. . . . Ingestion of a high-potassium diet is an important aspect of dietary therapy in diuretic-treated hypertensive individuals. There are no valid data to indicate just how high the potassium intake should be, but a diet providing 3,900 mg. (100 mEq) daily is a reasonable goal in treating adults. Supplements of potassium (as potassium chloride) may be needed to achieve this goal, as dietary means alone may not be adequate."[1]

In this statement, the last sentence addresses itself to the really important issue: are dietary means alone capable of correcting diuretic-induced hypokalemia? Many dietitians, nutritionists, nurses, and diet-oriented physicians have advised hypertensives to drink fruit juices, eat bananas, and use dietary recommendations on potassium-rich foods as provided by pharmaceutical companies (Table 1). Equally, many patients and their advisors have been disappointed in their failure to demonstrate any appreciable effect on the serum potassium concentration. To our knowledge, few have ever questioned the absorption of potassium and have undertaken appropriate measurements. A lead towards solving this important problem was reported in 1965 when Kassirer et al.[2] presented evidence that "hypokalemic alkalosis induced by adrenal steroids and sodium bicarbonate cannot be corrected by the administration of potassium unless chloride is provided simultaneously. . . . These observations may be particularly pertinent in the management of digitalized patients undergoing diuretic therapy, many of whom are prone to the development of potassium deficiency . . . From the study of hypokalemic, hypochloremic alkalosis in man . . . it is now abundantly clear that the alkalosis is unaffected by a diet high in potassium content if chloride intake is simultaneously restricted."

* Dr. Heyden is Professor of Community and Family Medicine, Duke University Medical Center, Durham, NC 27710; Dr. Hames is Principal Investigator, HDFP Center, Evans County, GA (NHLBI); Claxton, GA 30417; and Dr. Tarlton is Associate Professor, Dept. of Anesthesiology, Duke University Medical Center, Durham, NC 27710.

Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

TABLE 1 — Potassium-Rich Foods

Foods	Average Portion	Potassium (in mg.)	Calories	Sodium (in mg.)	Foods	Average Portion	Potassium (in mg.)	Calories	Sodium (in mg.)
FRUITS					MEATS				
☐ Orange	1 medium	360 mg.	95	0.8	☐ Hamburger	3 ounces	290 mg.	310	92.0
☐ Grapefruit	1 cup	380 mg.	75	1.0	☐ Beef chuck	3 ounces	310 mg.	260	44.0
☐ Banana	1 medium	630 mg.	130	0.8	☐ Beef round	3 ounces	340 mg.	200	58.0
☐ Strawberries	1 cup	270 mg.	55	1.2	☐ Rib roast	3 ounces	290 mg.	270	92.0
☐ Avocado	one half	380 mg.	275	3.4	☐ Turkey	4 ounces	350 mg.	300	46.0
☐ Apricots	3 medium	500 mg.	55	0.7					
☐ Dates	1 cup	1390 mg.	500	1.8					
☐ Watermelon	one-half slice	380 mg.	95	1.0					
☐ Cantaloupe	one-half melon	880 mg.	75	46.0	VEGETABLES				
☐ Raisins	1 cup	1150 mg.	425	34.0	☐ Tomato	1 medium	340 mg.	30	4.5
☐ Prunes	4 large	240 mg.	90	2.4	☐ Artichoke	1 medium	210 mg.	30	22.0
JUICES					☐ Brussels sprouts	1 cup	300 mg.	35	11.0
☐ Orange	8-oz. glass	440 mg.	105	9.0					
☐ Grapefruit	8-oz. glass	370 mg.	130	1.0					
☐ Prune	8-oz. glass	620 mg.	170	5.0					
☐ Pineapple	8-oz. glass	340 mg.	120	1.2					

In retrospect, it is amazing that it took another 15 years until the chloride content of potassium-rich foods was actually questioned. A group of investigators from Case Western Reserve University was impressed by the absence of efficacy of fruit and vegetable juices to repair potassium deficiency. Since no data on chlorides are available from the Agricultural Handbook, Miller et al.[3] set out to measure the chloride levels of the eight most frequently recommended juices. Table 2 demonstrates that chloride is present in significant amounts only when the sodium content of the juice is high. Unfortunately for the hypertensive patient, an increase in dietary sodium is likely to blunt the antihypertensive effects of the diuretic as well as to increase potassium losses.

TABLE 2 — Sodium, Potassium, and Chloride Content of Juices (mEq/liter)[3]

	Sodium	Potassium	Chloride
Apple juice	**1.2[a]**	**23.5**	**0**
Carrot juice[b]	**25.0**	**52.0**	**28.5**
Grape juice	**2.8**	**29.0**	**0**
Grapefruit juice	**0.2**	**35.5**	**1.0**
Orange juice	**0.2**	**50.0**	**1.5**
Pineapple juice	**0.2**	**33.5**	**9.5**
Prune juice	**6.4**	**56.0**	**0**
Tomato juice[b, c]	**130.5**	**57.0**	**129.0**

[a] Numbers shown are the averages of duplicate analyses.
[b] Specimens required centrifugation: supernatants were analyzed.
[c] Salt added.
(Miller, Sanford A., Roche, Patrick A., Srinivasan, Padma, and Vertes, Victor: Amer. J. Clin. Nutrit. 32:1757, 1979.)

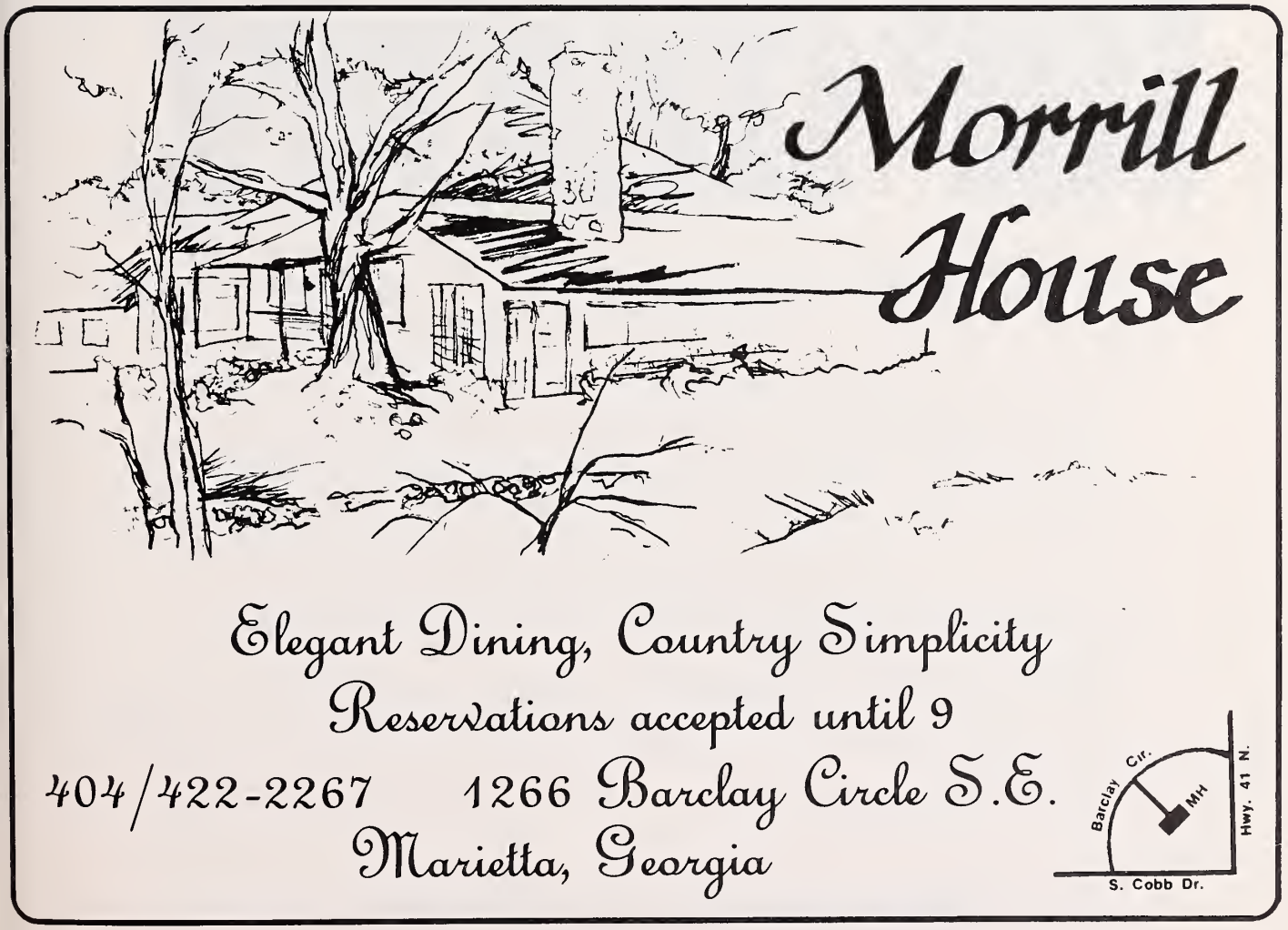
There can be no question that dietary potassium may play an important role in the primary prevention of hypertension. In this situation, *potassium may be retained and utilized even without chloride, since chloride serum levels are normal,* undisturbed by diuretics. This might be of clinical relevance for the black population whose potassium intake is considerably lower than whites and who display a markedly higher incidence of hypertension than the white population. If results of animal experiments were applicable to man, one would hope to achieve primary prevention of hypertensive blood pressure levels by simply restricting the sodium

intake and doubling the potassium intake to 4000 mg/day over the required optimal intake. In other words, fruit and vegetable juices do contribute to the serum potassium concentration as long as the patient is not using diuretics.

The average hypertensive patient, or more specifically, 60% of patients with essential hypertension, are overweight (≥20% above normal weight). So to advise them to eat a banana (which is completely devoid of chloride but contains 630 mg. of potassium[4]) that contains 100 calories is not the solution. These patients cannot afford the 100 extra calories per banana, the 110 extra calories per average glass of grapefruit or orange juice, etc. This statement in no way negates the importance of dietary potassium in the primary prevention of hypertension among relatives of hypertensive patients who are in the upper 5% of the distribution curve of blood pressure levels and are not taking diuretic drugs. But in view of the widespread use of diuretic therapy among the hypertensive population, it is important that dietitians, nutritionists, nurses, and physicians advise their patients to restrict their sodium intake and to use potassium chloride preparations to correct potassium deficiency. Of the three electrolytes which decrease during long-term diuretic therapy, potassium, sodium, and chlorides, only the latter ones are markedly excreted through the urine and that is the one electrolyte which needs replacement before one can hope to achieve dietary correction of hypokalemia.

References

1. National Academy of Sciences and Committee on Sodium-Restricted Diets. Sodium-restricted diets and the use of diuretics: rationale, complications, and practical aspects of their use. Washington, DC, 1979.
2. Kassirer JP, Berkman PM, Lawrenz DR, Schwartz WB. The critical role of chloride in the correction of hypokalemia alkalosis in man. Am J Med 1965;38:172.
3. Miller SA, Roche PA, Srinivasan P, Vertes V. Chloride and potassium-rich foods. Am J Clin Nutrit 1979;32:1757.
4. Personal communication by Sanford A. Miller, Dec. 6, 1979.



We're not asking you for money.

Just a few words. To people who need us but don't know we exist.

We're Recording for the Blind. We're already helping more than 13,000 handicapped students. But there are a lot more out there who need our help.

You know who they are. In your work you come across students who are blind, dyslexic or physically unable to handle books. These are the students we help. Since they cannot read their textbooks, we do it for them. On tape. And we send the tapes to the students free of charge.

All we want you to do is tell eligible students about us. Have them contact: Student Services, RFB, Inc., 215 East 58th Street, N.Y., N.Y. 10022, (212) 751-0860. We'll take it from there.

It's such a little thing to ask.

Recording for the Blind is a non-profit organization. All contributions are tax-deductible.

Recording for the Blind, Inc.

an educational lifeline.

Evaluation of the Abnormal PAP Smear — Colposcopy or Conization?

JOHN L. POWELL, M.D., *Atlanta**

PAPANICOLAOU (Pap) smears remain the most effective and efficient method for screening for cervical neoplasia. The frequency with which patients should be followed will depend largely on the degree of that individual's risk for the development of cervical neoplasia. A history of early onset of sexual activity and multiple pregnancies or multiple sexual partners places an individual in a high-risk category.

The management of a patient with an abnormal Pap smear has aroused a great deal of controversy over the past 3 decades. Now that a more coherent understanding of cervical neoplasia has been reached, better clarification of management is possible. The primary responsibilities of physicians confronted with a patient with cervical neoplasia are, first, to rule out the presence of deeply invasive carcinoma, and then to give appropriate treatment for the disease that is present. The initial step in the evaluation of the patient is when she is first seen. If there is a visible lesion present or if gross cervical cancer is apparent, the first step should be to take a biopsy that includes stroma for evaluation of invasiveness. If invasive carcinoma is found, treatment planning should be started without delay. If less disease is seen, the possibility of deep invasion still exists, since the error of undirected punch biopsy can be as high as 22%.[1]

If the lesion is equivocal, colposcopic evaluation of the cervix, with directed punch biopsies, is indicated. In the absence of colposcopy, Schiller staining of the cervix with multiple biopsies of the positive areas, plus a thorough endocervical curettage, can be substituted with good results.

A flow chart which suggests the appropriate management for patients based on their Pap smear was published by Nelson, Averette, and Richart in the American Cancer Society publication entitled "Dysplasia and Early Cervical Cancer."[2] This flow sheet is divided into two parts, indicating when colposcopy is not available vs. when colposcopy and skilled colposcopists are available (Figures 1 and 2). Since coloscopy and skilled colposcopists are available in Atlanta, we feel that all patients with abnormal Pap smears in this area should have colposcopy.

When colposcopy is available, the exact site of the lesion and its complete extent can be evaluated in most cases. A differential diagnosis between neoplasia and inflammatory atypia can be made, and early invasive lesions can be biopsied directly. The very experienced colposcopist can reliably rule out the presence of frankly invasive carcinoma and, with a high degree of accuracy, can diagnose the degree of CIN present. A reasonably skilled colposcopist can at least direct the initial biopsies and identify those more advanced lesions in which the expertise of a gynecologic oncologist is needed.

* Dr. Powell practices gynecologic oncology. His address is 5669 Peachtree-Dunwoody Rd., NE, Atlanta, GA 30342. Direct reprint requests to him at that address. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

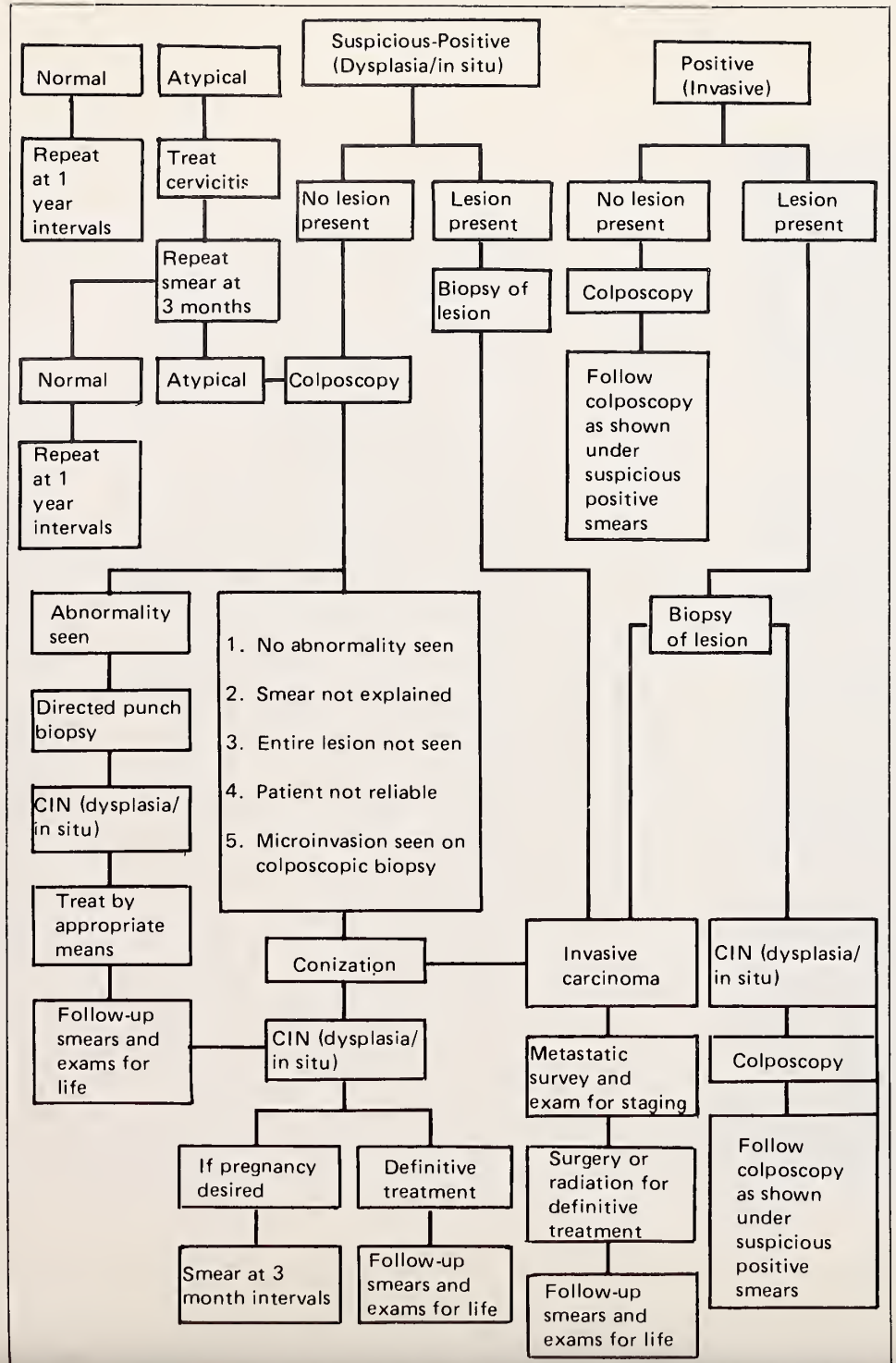


Figure 1 — Cervical smear flow chart when colposcopy and skilled colposcopist are available.

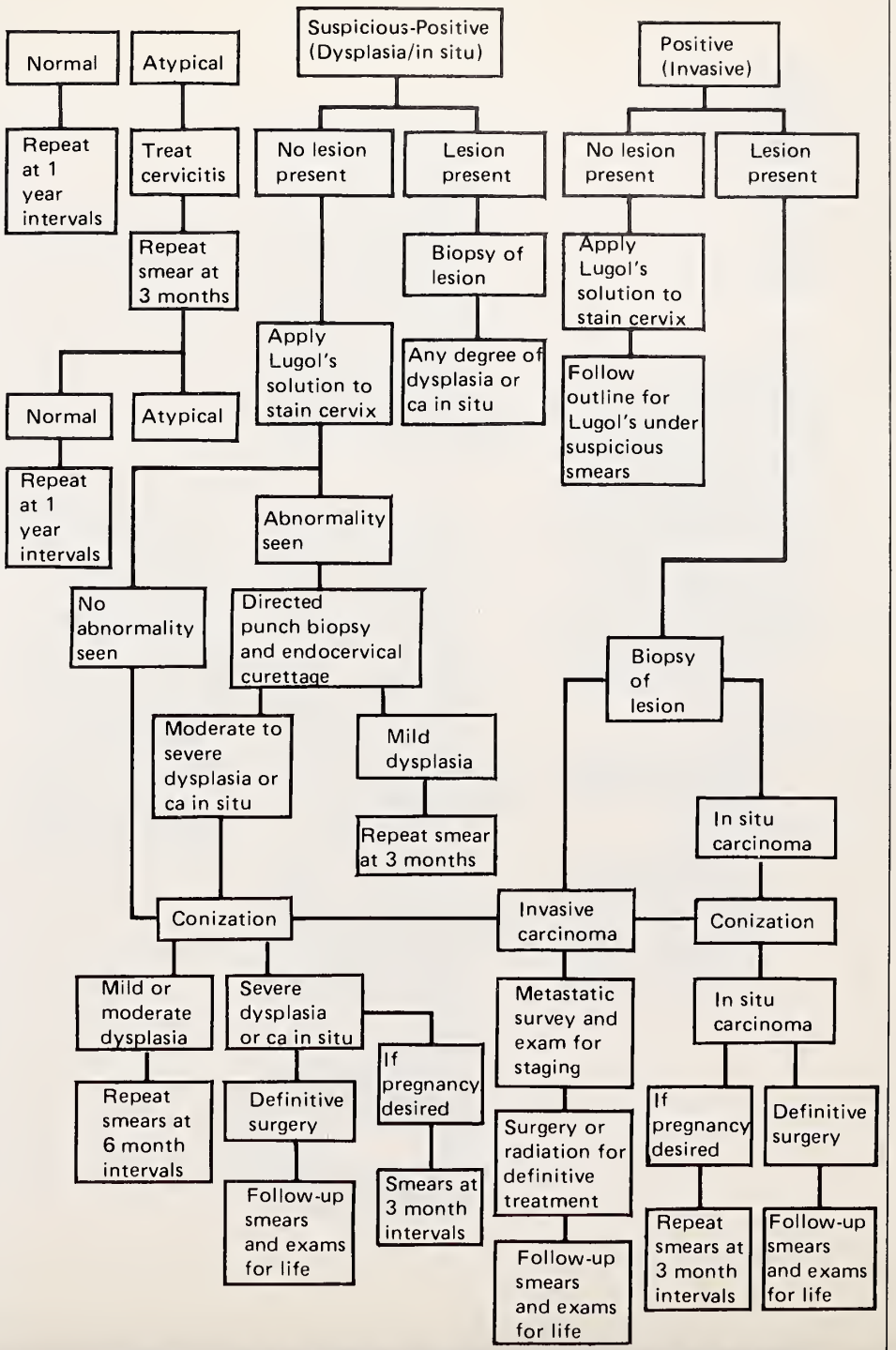


Figure 2 — Cervical smear flow chart when colposcopy is not available.

While the technique of colposcopy is relatively simple, the interpretation of results is related directly to experience. The colposcopist who attempts to manage disease beyond his or her skill may hopelessly complicate treatment and may thus reverse the beneficial effect of the proper use of colposcopy by sacrificing the patient's chance for cure of her disease. Such a responsibility demands recognition of one's limits and the ready availability of consultation with more experienced colposcopists and with trained gynecologic oncologists.

At the time of colposcopy, directed biopsies of all suspicious areas are taken and an endocervical curetting is done. The latter should be included by all colposcopists, since an occasional lesion may arise above the squamo-columnar junction within the endocervical canal as a result of artifact. In addition, an adenomatous endocervical lesion may coexist with squamous lesions and may otherwise escape detection. Urcuyo, Rome, and Nelson[3] and Shingleton, Gore, and Austin[4] have reported on the value of endocervical curettage performed as an integral part of the colposcopic examination for patients with abnormal cervical cytology. It is their feeling and ours that endocervical curettage appears to be of value, since a frankly invasive carcinoma can be diagnosed and cone biopsy avoided by integrating this procedure into the process of evaluation. This is particularly appropriate when the entire transformation zone is not fully visualized because it extends into the endocervical canal or when it is not visualized at all.

The aims of colposcopy are to rule out cancer, to localize the most abnormal site for biopsy, to evaluate the extent of the lesion, and to fully evaluate the squamo-columnar junction. When these criteria are met, colposcopy is satisfactory. If any are not, the examination is unsatisfactory, and the therapist must resort to other means of diagnosis. Unsatisfactory examination occurs in about 12% of women of reproductive age, and increases markedly after menopause.[5] In addition, endocervical extension becomes more common as the degree of CIN increases, with an incidence of up to 30% in extensive carcinoma in situ.

Cervical conization should never be performed prior to thorough evaluation of the cervix, both by direct inspection and colposcopic examination with punch biopsies and endocervical curettings, since incomplete removal of the invasive disease both complicates any subsequent therapy unnecessarily and can significantly decrease survival after any form of treatment. In addition, conization not directed by colposcopy can leave intraepithelial or invasive disease in 10% to 50% of all cases.[6] The need for conization can be eliminated in a large percentage of patients through skilled use of colposcopy and directed use of biopsies. This will avoid the expense and potential complications of conization which include risks of general anesthesia, hemorrhage, transfusion reactions, infection, cervical stenosis, and cervical incompetence. Austin et al.[7] reported in 1978 that the average cost of cervical conization was $923.70, while the cost for colposcopic evaluation and biopsy of the cervix was $106.00.

If colposcopy is satisfactory (the transformation zone is completely visualized and evaluated, the Pap smear is equal to the histology, and the endocervical curetting is negative), early CIN, small areas of carcinoma in situ with no suspicion of invasive disease or focal carcinoma in situ arising in lesser degrees of CIN, can be considered to be completely evaluated.

Further evaluation will be necessary in more advanced CIN that extends into the endocervical canal, in lesions in which microinvasion cannot be conclusively ruled out, or when microinvasion is present on punch biopsy. Direct conization aimed at removing all of the colposcopically visualized lesion plus upper and lower margins of 5 mm. is the next step. There is no need to remove the entire endocervical canal if the upper limits of the disease have been adequately seen and excised. A specimen must be serially sectioned to evaluate thoroughly the depth of invasion, the surface extent of the lesion, and the presence of vascular space involvement.

If colposcopy is satisfactory and negative, and if the Pap smear and endocervical curettings show no evidence of neoplasia, the patient can be followed regularly at 3 to 6 month intervals until two consecutive negative smears and colposcopic ex-

aminations have been obtained. Further follow-up is through regular Pap smears.

If the Pap smear is still abnormal in the presence of a normal and satisfactory colposcopic examination, further evaluation must be carried out. This should consist first of careful re-examination of the vagina, using colposcopy and/or Schiller staining. Inspection of the vulva and staining with Toluidine Blue may reveal another source of an abnormal Pap smear. If no lesion is found or if treatment of the vaginal and vulvar disease fails to eliminate the abnormal smear, cervical conization and dilatation and curettage (D & C) should be the next step. Under these circumstances, conization should be directed at removing the entire endocervical canal plus all portio disease.

In the event that the colposcopic examination is unsatisfactory (the transformation zone is not completely evaluated), the Pap smear shows a higher degree of neoplasia than that in the cervical biopsy, or the endocervical curettings show neoplastic tissue, conization and D & C must be resorted to again. The entire endocervical canal and as much of the ectocervix as is indicated by colposcopic examination or Schiller stain must be removed.

Pregnancy should not interfere with evaluation of the cervix. Pap smears and colposcopy can be carried out as usual. Portio biopsies can be safely carried out under colposcopic direction, but endocervical curettings should be avoided whenever possible. If invasion is excluded, the patient may be followed through pregnancy with cytologic and colposcopic evaluation repeated at 3-month intervals. Delivery may be allowed according to obstetric indications. There is no contraindication to vaginal delivery in the presence of CIN. If colposcopy is unsatisfactory or if invasion is questioned but not confirmed, a shallow, directed conization (excising only the colposcopically indicated areas) can be carried out with relative safety.[1] Care should be taken to avoid removing any excess endocervical canal beyond that necessary to completely excise the lesion. Stafl and Mattingly[8] reported a 32% complication rate in 28 pregnant patients undergoing conization before use of colposcopy in their clinic. Averette et al.[9] reported abortion as a major complication in 11 of 33 patients having conization during the first trimester of pregnancy. In contrast to multiple punch biopsies or shallow cones, colposcopically directed biopsies give excellent diagnostic accuracy and prevent major complications.[10]

If no invasive disease is detected during pregnancy, the patient can be re-evaluated 6 to 8 weeks postpartum, and a final treatment plan can be made at that time. The value of colposcopy is pointed out by the reduced need for diagnostic conization, which is avoided in about 85% of all patients. Moreover, conization is rarely needed in pregnancy when colposcopy is used. In the recent series reported by Tunca, Franklin, and Clark,[10] 104 pregnant patients were managed by colposcopy, and only two of them required conization during pregnancy.

References

1. Boutselis JG. Intraepithelial carcinoma of the cervix associated with pregnancy. Obstet Gynecol 1972; 40:657.

2. Nelson JN, Averette HE, Richart RM. Dysplasia and early cervical cancer. American Cancer Society Professional Education Publication, 1975.

3. Ureuyo R, Rome RM, Nelson JH. Some observations on the value of endocervical curettage performed as an integral part of colposcopic examination of patients with abnormal cervical cytology. Am J Obstet Gynecol 1977; 128:787.

4. Shingleton HN, Gore H, Austin JM. Outpatient evaluation of patients with atypical papanicolaou smears: contribution of endocervical curettage. Am J Obstet Gynecol 1976; 126:122.

5. Stafl A. Colposcopy in diagnosis of cervical neoplasia. Am J Obstet Gynecol 1973; 115:286.

6. Anderson B. Management of early cervical neoplasia. Clin Obstet Gynecol 1977; 20:815.

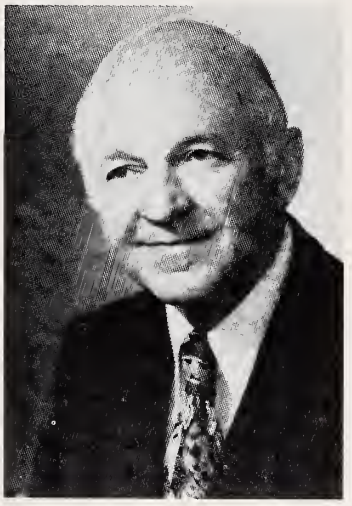
7. Austin JM, Charles ED, Shingleton HM. Colposcopy or cervical conization? An economic comparison. South Med J 1978; 71:580.

8. Stafl A, Mattingly FR. Colposcopic diagnosis of cervical neoplasia. Obstet Gynecol 1973; 41:168.

9. Averette EH, Nezamoddin N, Sanfors LY, et al. Cervical conization in pregnancy. Am J Obstet Gynecol 1970; 106:543.

10. Tunca JC, Franklin EW, Clark JC. Colposcopic management of abnormal cervical cytology during pregnancy. South Med J 1976; 69:705.

medicard



I am proud to present the one card that increases your cash flow -- MEDICARD.

Whether your facility is a one person operation or a large health care group, we offer three day turnaround on your funds, less a minimal discount fee. In addition, we prepare tailor-made billing systems for your particular needs, and offer accounts receivable programs for your consideration.

As a provider of health care, you may offer to MEDICARD holders the opportunity to charge visits to your office, the hospital emergency room and outpatient clinics, prescriptions, eyeglasses and contact lenses, laboratory tests, wheelchairs, crutches and braces, hearing aids, physical therapy, convalescent and special health care -- anything and everything for good health.

MEDICARD was created to provide consumers with a line of credit for medical and health care expenses at a time when these costs are skyrocketing. We provide a substantial line of credit so that people do not have to dig into their savings or borrow to the limit of their bank credit cards.

Our research has shown there is a great need for these services. We stand ready to offer you, and the community, financial good health.

Here's to good health, for everyone, with MEDICARD.

Sincerely,

Harold A. Dye, President

MEDICARD INCORPORATED
31 Executive Park Drive / P.O. Box 95329 / Atlanta, Georgia 30347 / (404) 325-2009

president's letter



My View of Leadership

I AM GRATEFUL for this honor to serve the Medical Association of Georgia.

My unalterable position is to support and to promote the purposes of this organization as documented in Article I of our Constitution, and in Chapter I, Section I, of our Bylaws.

I believe that the strength of our organization lies in mutual trust and working together in unity of purpose.

We have a choice: We can curb our wants, or we can take off our coats and find out how hard we must work to satisfy our wants.

Effective leadership involves unwavering belief, tireless effort and commitment. Leadership must always be directed to the goal of making every individual feel worthwhile.

New times bring new needs, new challenges, and new opportunities.

I look forward to these challenges and opportunities with pride, confidence, and determination.

Sincerely,

H. Hilt Hammett, Jr., M.D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

NEW MEMBERS

Alvig, Olav H., Newton-Rockdale—ACT—DR
Newton County Hospital, Radiology Dept., Covington 30209

Barry, William E., Crawford W. Long—N-2—D
740 Prince Ave., Athens 30601

Bergeron, Glynn A., Georgia Medical Society—N-1—DR
5252 Paulsen St., Savannah 31405

Berry, John B., Walker-Catoosa-Dade—ACT—NS
110 Memorial Medical Bldg., Chattanooga, TN 37404

Bishop, Emmett R., Jr., Richmond—ACT—P
Medical College of Georgia, Psychiatry Dept., Augusta 30912

Creel, James H., Walker-Catoosa-Dade—ACT—EM
Tri-County Hospital, Ft. Oglethorpe 30742

Daniell, Duren, Bibb—ACT—ORS
90 Fifth St., Macon 31208

Dasher, Marion N., Jr., Richmond—N-2—GE
820 St. Sebastian Way, Ste. 7-B, Augusta 30902

DeHaven, Joseph W., Georgia Medical Society—N-2—END/IM
5105 Paulsen St., Savannah 31405

Dewberry, James W., Georgia Medical Society—N-2—ORS
7 St. Joseph's Professional Plaza, Savannah 31406

Feegal, John R., MAA—ACT—PTH
Medical Examiner's Office, 50 Coca-Cola Pl., SE, Atlanta 30303

Forestner, John E., MAA—ACT—AN
Henrietta Egleston Hospital, Atlanta 30322

Gannon, Carmen, Georgia Medical Society—N-2—IM
1801 E. Broad St., Savannah 31401

Glass, T. Franklin, III, Bibb—ACT—DR
770 Pine St., Ste. L-10, Macon 31201

Hammad, W. David, MAA—N-2—PD
315 Boulevard, NE, Ste. 428, Atlanta 30312

Jackson, Joseph L., Burke—N-2—FP
304 Jones Ave., Waynesboro 30830

Kennerly, R. Michael, Georgia Medical Society—N-2—CDS
5112 Paulsen St., Savannah 31405

Kreh, Gustave M., Georgia Medical Society—N-1—PD
4 Medical Arts Bldg., Savannah, 31405

Madeley, James B., DeKalb—N-2—ORS
1462 Montreal Rd., Ste. 114, Tucker 30084

Manns, William J., Dougherty—N-2—IM
1104 N. Monroe, Albany 31701

Maziar, Howard M., MAA—ACT—P
3400 Peachtree Rd., NE, Ste. 1211, Atlanta 30326

McGinnis, John C., Georgia Medical Society—ACT—PM
11705 Mercy Blvd., Savannah 31406

Medart, William S., Georgia Medical Society—ACT—PTH
6205 Abercorn St., Ste. 200, Savannah 31405

Natrajan, Puthugramam K., Muscogee—N-2—OBG
The Medical Center, OB/GYN Dept., Columbus 31901

O'Neill, John C., III, Georgia Medical Society—N-2—IM/EM
P.O. Box 9787, Savannah 31402

Othman, Mufid A., Bibb—ACT—IM/NEP
770 Pine St., Ste. 220, Macon 31201

Parker, Frank M., Peach Belt—N-2—OBG
105 Briarcliff Rd., Warner Robins 31093

Pattison, E. Mansell, Richmond—ACT—P
Medical College of Georgia, Psychiatry Dept., Augusta 30912

Pendleton, Eugene B., MAA—ACT—ORS
4536 Chamblee-Dunwoody Rd., NE, Ste. 281, Atlanta 30338

Peskoe, Stanley T., Bibb—N-2—NEP/IM
380 Hospital Dr., Ste. 345, Macon 31201

Purcell, Dent W., Georgia Medical Society—ACT—TR
P. O. Box 23089, Savannah 31403

Savage, John B., Richmond—I&R—ORS
1703 Holly Hill Rd., Augusta 30904

Sawyer, Benjamin F., IV, Georgia Medical Society—ACT—GP
1915 Eisenhower Dr., Savannah 31406

Schlosnagle, David C., DeKalb—I&R—PTH
2999 Cedar Brook Dr., Decatur 30030

Sistrunk, T. Lewis, Cobb—N-2—R
600 W. Memorial Dr., Dallas 30132

Sullivan, Humbert G., Richmond—ACT—NS
Medical College of Georgia, Neurosurgery Dept., Augusta 30912

Tan, Josefina C., Georgia Medical Society—ACT—GP/AN
P. O. Box 38, Guyton 31312

Tauber, Harvey B., MAA—ACT—U
4536 Chamblee-Dunwoody Rd., NE, Atlanta 30338

PERSONALS

Second District

William E. Mayher III, M.D., Albany, was recently elected Chairman of the Board of Blue Shield of Georgia/Columbus, Inc.

Fourth District

William E. Silver, M.D., of Atlanta, presented a paper, "Indication for Supra-tarsal Fixation Upper Blepharoplasty," to the American Association of Cosmetic Surgery at its annual meeting in New Orleans, March 14.

Fifth District

Raymond L. Cox, M.D., Atlanta, was recently appointed to Georgia Baptist Medical Center's Medical Staff in the Ob/Gyn Department.

The Christian Council of Metropolitan Atlanta recently awarded **Leila Denmark, M.D.,** of Atlanta the Community Service Award.

N. Vildan Erkan, M.D., co-authored "Theophylline-Induced Seizures in Accidentally Overdosed Neonates," which was published in the March 1980 issue of *Pediatrics*.

Charles R. Hatcher Jr., M.D., Atlanta, spoke to the Thomson Rotary Club on February 21. His presentation was entitled, "Recent Advances in the Surgical Treatment of Heart Disease."

Joseph Hoffman, M.D., was recently sworn in as president of the Atlanta Medical Association.

T. E. Whitesides, M.D., Atlanta, presented a paper, "The Parameters of Compartment Syndromes and Fasicotomy," at the opening session of the American Academy of Orthopedic Surgeons February 7. The meeting was held in Atlanta.

Seventh District

Joseph G. Bussey Jr., M.D., Austell, presented a scientific exhibit on postoperative pain control using transcutaneous electrical nerve stimulation at a meeting of the Association of Operation Room Nurses in Atlanta. He was also one of the guest faculty at Emory University School of Medicine's postgraduate seminar on transcutaneous electrical nerve stimulation.

The Hospital Authority of Bartow County recently approved staff privileges for **Richard Young, M.D.,** Rome, at Sam Howell Memorial Hospital.

Tenth District

James Ford III, M.D., recently moved his practice from North Augusta, South Carolina, to Wrens, Georgia.

SOCIETIES

Buford Harbin, M.D., Rome, spoke to the **Gordon County Medical Society** at its February meeting. His topic was Respiratory Care and Arterial Blood Gases.

DEATH

J. R. Shannon Mays

Macon's first psychiatrist, J. R. Shannon Mays, M.D., 76, died Sunday, March 30, 1980, after a short illness.

Dr. Mays was active in psychiatric care in Macon for over 30 years. The psychiatric unit of the Medical Center of Central Georgia is named in his honor. He was a pioneer in the private practice of psychiatry in the Middle Georgia area. In 1958, he set up the first psychiatric service in a general hospital and was the organizing president of the Georgia Psychiatric Association.

Dr. Mays was born July 2, 1903, in Lincolnton, Georgia and moved to Macon at the age of 12. After graduating from Mercer University in 1926, he received his medical degree in 1930 from the University of Georgia Medical School in Augusta.

He served 5 years in the U.S. Army and retired from active duty in 1946 with the rank of Lt. Colonel. He was awarded the Legion of Merit for his work in the China-Burma-India theatre. After World War II, Dr. Mays returned to Macon to set up practice and joined the staff of the Medical Center. For many years he was clinical director of the Macon-Bibb County Child Guidance Center. He served under five governors as a member of the Georgia Sanity Commission. He was a member of the Bibb County Medical Society, the Medical Association of Georgia, the American Medical Association, as well as numerous other medical associations.

Dr. Mays is survived by his wife, a son, a brother, and two sisters.

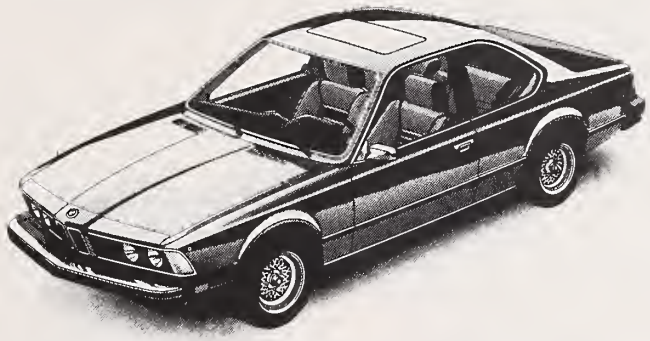
In lieu of flowers, the family requests that contributions be made to the Shannon Mays Memorial Scholarship Fund, Mercer University.

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



THE ULTIMATE DRIVING MACHINE.

BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER

21 Years' Service

Serving the General Insurance needs of the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Classifieds

PHYSICIANS WANTED

The Department of Neurology of Emory University School of Medicine has a full-time academic position available July, 1980, as Deputy Chief of the Neurology Service, Grady Memorial Hospital, Atlanta, Georgia. The appointment is at the level of assistant professor. The position involves participation in an active patient-care, teaching and clinical research program based in a center-city hospital which is a major element in the teaching program and community services of Emory University School of Medicine. Clinical competence and teaching ability are essential. Special clinical and research interests are highly desirable as is training and experience in internal medicine. Laboratory space is available for clinical research. We are especially interested in learning of women and minority candidates. Emory University is an affirmative action and equal opportunity employer. For information write: Herbert R. Karp, M.D., Professor and Chairman, Department of Neurology, Emory University School of Medicine, 69 Butler St., SE, Atlanta, GA 30303. PH: 404/588-4013.

Surgery Director — Opening for Director of Residency Training Program in Surgery with Pensacola Educational Program, Pensacola, Florida, for Board certified physician. Total program of 50 residents in six different residencies associated with 4 different hospitals in community-based educational program. Salary competitive with excellent fringe benefits of paid vacation, liability insurance, health and disability insurance, paid educational and professional trips. Program affiliation with several large medical schools. Gulf Coast living at its best, and health care in immediate area of over ¼ million. Must fill position by July 1, 1980. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education, 904/477-4956, or send CV to Director of Medical Education, Pensacola Educational Program, 5149 North 9th Ave., Ste. 307, Pensacola, FL 32504.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call 634-1234.

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

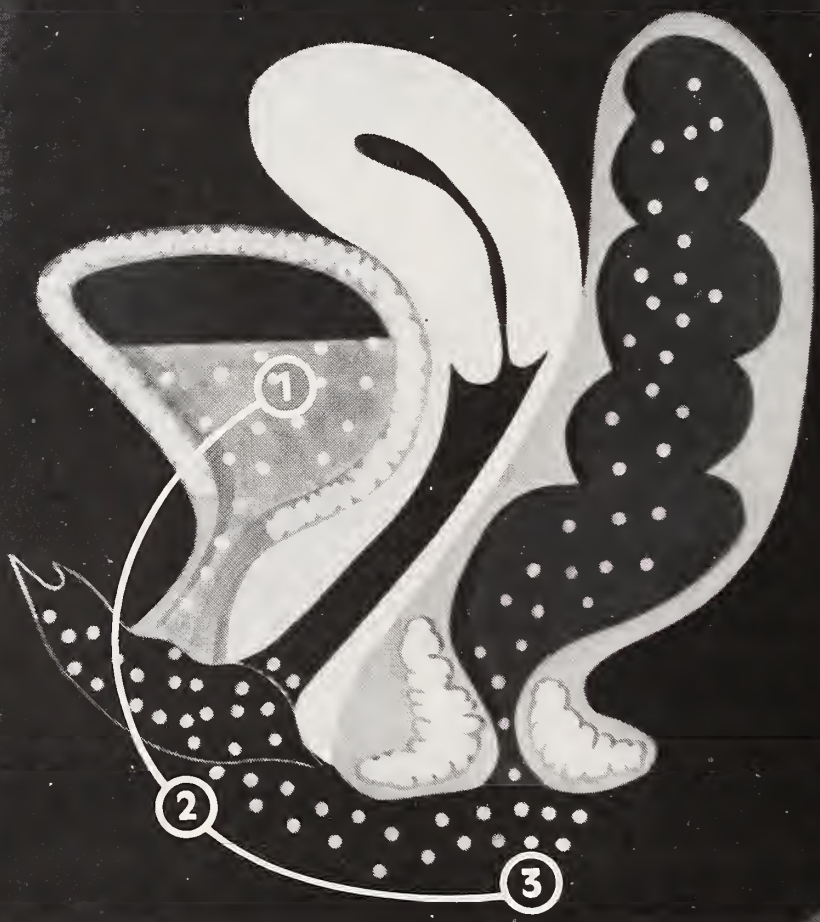
ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introi colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

Index to Advertising

Vol. 69 May 1980 No. 5

American Alliance for Health 354
American Medical Association 364
Ballard, Walter, Optical Company 412
Brawner Psychiatric Institute 390
Burroughs Wellcome Company 354, 381
Carriage Trade Dinner Club 341
Classifieds 408
Clinical Weight Loss 339
Decatur Hearing Aid Service 407
Dickey-Mangham Company 392
Fenwick Hall 350
Fulton Federal Savings and Loan Association 334
Georgia National Guard 362
Georgia Rehabilitation Center 414
Georgia Society of CPA's 358
Global Imports 407
The Great Cherokee Trading Company 412
Hickman-Datsun 392
Insurance Corporation of America 342, 343
Janssen Pharmaceuticals 356, 357
JMAG Classifieds 408
Lilly, Eli, and Company 376
Medicard 403
Merck, Sharp & Dohme 382, 383, 384
Metro Ambulance 380
The Morrill House 397
Office Communications, Inc. 366
Ortega Pharmaceutical Company, Inc. 389
Peachford Hospital 372, 373
Peachtree and Parkwood Mental Health Center and Hospitals 344
Potter-Holden and Company 407
Psychiatric Institute of Atlanta 349
Ridgeview Institute 365
Roche Laboratories 332, 333, 334, 363, 374, 375, 409, 410
Rorer, William H., Inc. 352, 353, 354
Schering Corporation 412, 413
Smith, Kline, & French 351
U. S. Department of Health 410
Valley Psychiatric Hospital 408
Weight Watchers of Greater Atlanta 392
Willingway Hospital 361
Wyeth Laboratories 393, 394

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

The Great CHEROKEE TRADING COMPANY®

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

- provides effective symptomatic relief
- *b.i.d.* dosage simplifies therapy
- scored tablet for dosage flexibility

OPTIMINE®
azatadine maleate, 1 mg. tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma; increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

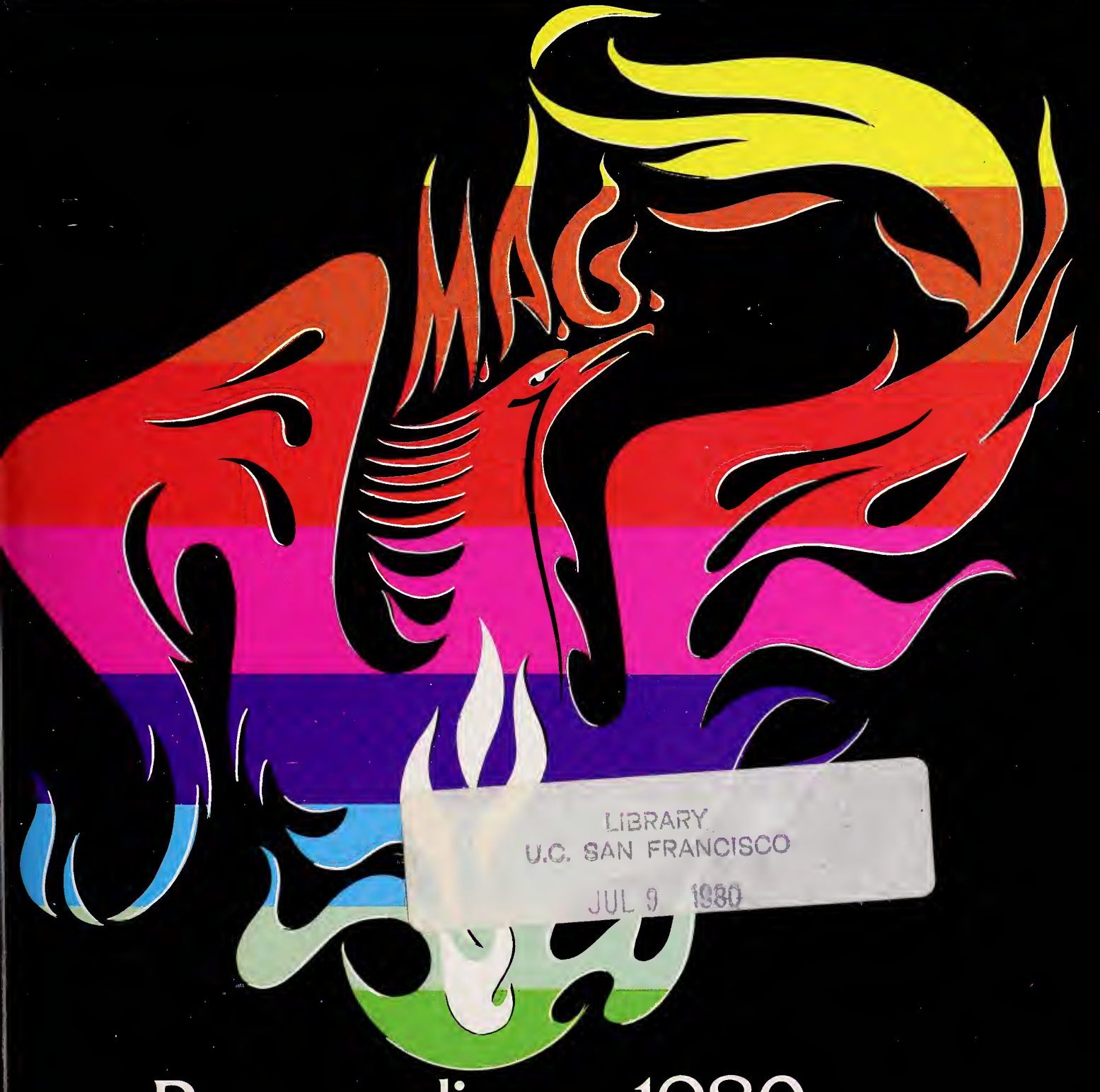
FEBRUARY 1977 11055010

For more complete details, consult package insert or Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

Schering Corporation
Kenilworth, New Jersey 07033

SMW-417 I

JOURNAL
of the medical association of
georgia
ISSN·0025·7028 JUNE / 1980



LIBRARY
U.C. SAN FRANCISCO
JUL 9 1980

Proceedings 1980

THINK DRY

Schering



THINK
OPTIMINE®
azatadine maleate, 1 mg, tablets

FIRST
for relief of allergy symptoms

℞ only

Please see adjacent brief summary of prescribing information.

Copyright © 1980, Schering Corporation. All rights reserved.

- provides effective symptomatic relief
- *b.i.d.* dosage simplifies therapy
- scored tablet for dosage flexibility

OPTIMINE®

azatadine maleate, 1 mg. tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma; stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977 11055010

For more complete details, consult package insert or Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

Schering Corporation
Kenilworth, New Jersey 07033

SWW-4171

Serving the General Insurance needs of the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 6

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director and Director of Legislative Activities
Stephen L. Daniel, Ph.D., Assistant Executive Director — Education
J. Tom Sawyer, Assistant Executive Director — Administration
Kenneth M. Williams, Director of Public and Professional Relations
Joyce Butler, R.N., Director of Medical Practice
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

OFFICIAL PROCEEDINGS OF THE 1980 ANNUAL SESSION BUSINESS MEETING, APRIL 24-27, ATLANTA HILTON, ATLANTA, GEORGIA

421 Proceedings Index
423 Photograph Index
432 Highlights of the 1980 Annual Session

GENERAL SESSION

435 First Session, Thursday, April 24
558 Final Session, Sunday, April 27

HOUSE OF DELEGATES

441 First Session, Thursday, April 24
469 Second Session, Saturday, April 26
521 Third Session, Sunday, April 27

515 AUXILIARY HIGHLIGHTS

EDITORIAL

568 An Introduction of the New MAG Officers

THE ASSOCIATION

570 President's Letter/Strength in Confidence
H. Hilt Hammett, Jr., M.D.
571 New Members
571 Personals
572 Societies
572 Deaths

INCIDENTAL INTELLIGENCE

420 MAG Science Awards
420 Some Reminders and Helpful Tips Re Prescription of Controlled Substances
420 Administration Cuts Proposed Health Budget
425 Medical Meeting Calendar

THE COVER

The phoenix — a symbol of Atlanta, host to the MAG's 126th Annual Business Meeting. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

MAG Science Awards

The MAG has honored two Georgia high school students for their exhibits in the medicine and health category at this year's Georgia Science and Engineering Fair, held April 10-12 at the University of Georgia in Athens. The Fair was quite a success, attracting over 1500 exhibitors and visitors.

Savings bonds awarded by the MAG went to: first prize winner **David Nahmias,** Briarcliff High School, Atlant for "Immune Electron Microscopy of Adenoviruses' and second prize winner **Duncan Fraser,** Briarcliff Hig School, Atlanta, for "The Rate of Repair of Ultraviol Damage in Satellite and Main Component Deoxyribon cleic Acid as Compared to Bulk Deoxyribonucleic Acid.

Some Reminders and Helpful Tips Re Prescription of Controlled Substances

Representatives of the American Medical Association (AMA) served on the Practitioners' Working Committee of the Drug Enforcement Administration (DEA) and helped formulate "Guidelines for Prescribers of Controlled Substances." At the interim meeting in December, the AMA House approved these guidelines. In general, the AMA states that "controlled substances have legitimate clinical usefulness, and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well being of patients." Most of them are already known to physicians but a summary of them is as follows:

A prescription must be signed by the prescriber, bear his full name, address, and DEA number. Most do not know and very few physicians comply with the requirement that the patient's address is supposed to be on the prescription. You should indicate the number of refill you wish. If none, so indicate because this can be inte preted as "PRN" by the pharmacist, or the patient ca mark the refills they want. As you know, Schedule I prescriptions have to be written, not called in, and canno be refilled. Schedules III, IV, and V may be called in o written and may be refilled five times as a maximum bu are good for only 6 months whether or not the patient ha had the prescription refilled. The guidelines stress pre scribing only the amount needed until the next check-up Pre-printed prescription blanks and institutional blank are discouraged. A final suggestion made to help preven alteration of your prescription by a patient is to hav check-off boxes printed on your blank which sho amounts within which the prescribed amount falls, i.e. 1-25, 26-50, 51-100, over 100.

Administration Cuts Proposed Health Budget

Congressional appropriations committees are considering the Administration's proposals for a further $500 million reduction in health program funding.

The cuts in an already Spartan health budget, made as part of President Carter's all-out drive to balance the budget to fight inflation, normally would receive short shrift in Congress, where health is usually apportioned generously. This year promises to be different, however, as Congress generally shares the Administration's concern about budget deficits.

In addition to the cuts for the fiscal year 1981 starting next October, the Administration is seeking reductions in appropriations for the current year and rescissions of appropriations already approved by Congress. Congress was asked to delay action on the $300 million Child Health Assurance Program, originally slated to take effect next fiscal year, and on legislation expanding Medicare and Medicaid benefits. There was even a 6-month postponement until 1983, of the Administration's National Health Insurance plan.

There was little policy evident in the indiscriminate, down-the-line budget paring of health programs. Disease prevention, mental health, alcoholism, and the National Health Service Corps, not to mention the Child Healt Assurance Program, had all been Administration fa vorites.

Proposed Health, Education, and Welfare cuts ar as follows:

Health Services Administration — cut by $11 million, including $47 million for the National Healt Service Corps, $21 million for community health cen ters, and $15 million for family planning.

Center for Disease Control — cut by $98 million led by $52 million for health incentive grants.

National Institutes of Health — cut by $91 millio plus another $41 million from this year's appropria tion.

National Cancer Institute — cut by $43 million.

National Heart, Blood, and Lung Institute — cu by $15.6 million.

Alcohol, Drug Abuse, and Mental Health Ad ministration — cut by $102 million for state formul grants.

Health Resources Administration — cut by $7 million including $38 million for local health planning

PROCEEDINGS INDEX

GENERAL SESSIONS

FIRST SESSION — THURSDAY, APRIL 24

MAG Deceased Members 435
Introduction of Distinguished Guests 436
Civic Endeavor Award 436
Distinguished Service Award 436
Family Physician of the Year Award 436
Sandoz Journalism Award 436
Certificates of Appreciation 437
Fifty Year Certificates 437
Life Members 437
AMA-ERF Checks 438
Membership Recruitment Film 438

FINAL SESSION — SUNDAY, APRIL 27

Installation of Officers 558
Acceptance Speech, H. Hilt Hammett Jr., M.D., for Office of President 566

AUXILIARY HIGHLIGHTS

Photos 515

HOUSE OF DELEGATES

FIRST SESSION — THURSDAY, APRIL 24

Attendance 441
Appointment of Committees 442
Adoption of Minutes 442
Nominations 442
Sixth District Director and Alternate Director Nominations 443
Directors and Alternate Directors 443

ANNUAL REPORTS

(Reference Committee to which referred in parentheses; NR = Not Referred.)

Officers' Reports
President
Recommendations 1, 2, 4, and 6 (A) 475
Recommendations 3 and 5 (F) 509
First Vice President (NR) 444
Chairman of the Board of Directors (A) 485
Secretary (NR) 445
Treasurer (F) 509
Speaker of the House (A) 483
Vice Speaker of the House (C) 545
Board of Directors (Budget 1980-81) (F) 511
Directors' Reports
AMA Delegation (A) 488
First District Medical Society (NR) 446
Second District Medical Society (NR) 447
Third District Medical Society (NR) 447
Sixth District Medical Society (NR) 447
Seventh District Medical Society (NR) 448
Eighth District Medical Society (NR) 448
Ninth District Medical Society (NR) 448
Tenth District Medical Society (NR) 449
Bibb County Medical Society (NR) 449
Cobb County Medical Society (NR) 449
DeKalb Medical Society (NR) 447
Floyd-Polk-Chattooga Medical Society (NR) .. 449
Georgia Medical Society (NR) 449
Medical Association of Atlanta (NR) 447
Muscogee County Medical Society (NR) 449
Richmond County Medical Society (NR) 450
Committee Reports
Access to Health Care (D) 493
AD HOC-Drugs (NR) 452
AD HOC-Principles of Medical Ethics (C) 556
AD HOC-Risk Management (NR) 460
Auxiliary (NR) 450
Cancer (D) 495
Cancer Supplemental Report (D) 495
Composite State Board of Medical Examiners (NR) 450
Constitution and Bylaws (A) 471
Constitution and Bylaws Supplemental Report (NR) 474
Cost Awareness (NR) 450
Education (D) 496
Education Supplemental Report (D) 498
Emergency Medical Services (C) 545
Health Planning (D) 500
Legislative (NR) 452
Maternal and Infant Health (NR) 456
Medical Aspects of Sports (NR) 457
Medical Practice (B) 534
Medical Practice Supplemental Report (A) 489
Medicine and Human Values (NR) 458
Membership (A) 488
Mental Health (NR) 458
Nursing (B) 538
Nutrition (D) 501
Occupational Health (NR) 458
Peer Review (NR) 502
Physicians' Assistants (B) 523
Physicians' Consultants Committee to the Disabled Doctors Program (A) 489
Physician-Lawyer Liaison (NR) 458
Prison Health Care (NR) 459
Public Health (C) 547
Public Relations (C) 530
Scientific Assembly (NR) 460
Special Delegate Report-Liaison with the AAMA (D) 503
Third Party Relations (C) 549
Third Party Relations Supplemental Report (C) 551
Truthful Advertising (NR) 461
Women Physicians in Organized Medicine (NR) 461
Department Reports
Georgia Medical Care Foundation (NR) 462
Journal of the Medical Association of Georgia (NR) 464

New Business – Resolutions
1—Legal Approval of MAG Resolutions (A) 490
2—Medicaid Complaints (C) 553
3—Finance Charge for Medical Billings (C) .. 548
4—Health and Safety of High School Athletes in the State of Georgia (C) 548
5—Robert Cumming Wilson (D) 494
6—Welfare of the Patient (D) 504
7—Involvement in Medical Issues (D) 505
8—Control of Nurse Practitioners of Medicine (B) 537
9—Expansion of Medical Schools (C) 556
10—Current Procedural Terminology-IV (D) .. 505
11—Membership of the American Medical Association (A) 491
12—Implementation of Malpractice Insurance Program (D) 506
13—Reimbursement by Third Party Payment Agencies (C) 553
14—Status of Efforts to Revise the Medicaid Provider's Manual (C) 554
16—MAG Officers (D) 506
17—Catastrophic Health Insurance (C) 549
20—Repeal of Section in Georgia's Worker's Compensation Laws Dealing with the Selection of Physicians (C) 555
21—Preferential Immigration Status of Physicians (D) 505
22—Disapproval of Supporting a Single Health Care Delivery System (B) 530
23—Rural and Urban Health Clinics (B) 536
24—Amending Section 9, 114-504 Selection of Physicians under the Georgia Worker's Compensation Law (C) 555
25—Out-Patient Insurance (D) 507
26—Position Statement on Health Maintenance Organizations (B) 527

SECOND SESSION — SATURDAY, APRIL 26

(Committee Reports, Reference Committee Recommendations, and House of Delegates Actions)

Report of Reference Committee A 471
Committee on Constitution and Bylaws 471
Addendum to Constitution and Bylaws Committee Report 473
Supplemental Report of the Constitution and Bylaws Committee 474
Attachment to the Constitution and Bylaws Report 474
Report of the President (Recommendations 1, 2, 4 and 6) 475
Report of the Speaker of the House 483
Report of the Office of the Chairman of the Board of Directors 485
Report of the AMA Delegation 488
Report of the Membership Committee 488
Physicians' Consultant Committee to the Disabled Doctors' Program 489
Medical Practice Committee Supplemental Report 489
Resolution 1 490
Resolution 11 490
Report of Reference Committee D 493
Committee on Access to Health Care 493
Resolution 5 494
Cancer Committee 495
Supplemental Report of the Cancer Committee .. 495
Committee on Education 496
Supplemental Report of the Committee on Education 498
Committee on Health Planning 500
Nutrition Committee 501
Peer Review Committee 502
Special Delegate Report of the MAG Advisor to Georgia Chapter, American Association of Medical Assistants 503
Resolution 6 504
Resolution 10 505
Resolution 21 505
Resolution 7 505
Resolution 12 506
Resolution 16 506
Resolution 25 507
Report of Reference Committee F 509
Report of the President (Recommendations 3 and 5) 509
Report of the Treasurer 509
Board of Directors — Budget 511

THIRD SESSION — SUNDAY, APRIL 27

Announcement of Election Results 521
Report of Reference Committee B 523
Committee on Physicians' Assistants 523
Resolution 26 527
Resolution 22 530
Committee on Public Relations 530
Medical Practice Committee 534
Resolution 23 536
Resolution 8 537
Committee on Nursing 538

A Special Resolution 540

Report of Reference Committee C 545
Report of the Vice-Speaker 545
Emergency Medical Services Committee 545
Public Health Committee 547
Resolution 3 548
Resolution 4 548
Resolution 17 549
Committee on Third Party Relations 549
Supplemental Report of the Committee on Third Party Relations 551
Resolution 2 553
Resolution 13 553
Resolution 14 554
Resolution 20 555
Resolution 24 555
Resolution 9 556
Ad Hoc Committee on the Principles of Medical Ethics 556

PHOTOGRAPH INDEX

Arnold, McAlpin H. 493
Anderson, Thomas 539
Asbell, Mrs. Jimmy R. 515
Astin, Mrs. Phil 515
Atha, John F. 545, 550
Atkins, Earnest C. 435, 436, 438, 495, 553, 559
Bailey, Joseph P. 438, 520, 521
Bain, James A. 438
Bateman, J. Dan 443, 539, 558
Bates, Mrs. John G. 517, 518
Berg, Robert 539
Blair, H. Duane 509, 512
Boyette, D. Morton 525
Brewer, Spencer S., Jr. 493
Brown, Mrs. Mark 515, 516
Bryant, Mrs. Milton 517, 518
Buchanan, L. C. 436, 438, 469, 538, 540, 557
Burgstiner, Carson B. 465, 495
Busbee, George 572
Cates, Mrs. Robert M. 515, 516
Chaney, Mrs. Ralph, Sr. 517, 518
Chastain, Mrs. George M. 515, 516
Clark, S. William 568
Collins, William C. 529, 558, 569
Curtis, Mrs. Walker S. 518
Daniel, Stephen 493
Davis, Mrs. Shelley C. 517, 518
Dixon, Sammie 558
Dowda, F. William 533
DuBois, Richard E. 529
Evans, Cassandra 572
Flores, Mrs. Jose Roberto 515, 516
Frank, Milton 510
Galloway, Ronald F. 450, 545, 550
Gardner, Hoyt D. 465, 469
Garner, Clyde D. 509
Glucksman, Irene 436, 518
Glucksman, Michel A. 513, 557, 558
Griffin, Richard A., III 444
Haltiwanger, Mrs. Earl 515
Hammett, H. Hilt, Jr.
..... 437, 469, 484, 495, 553, 558, 559, 566, 568
Harrison, Mrs. George 517, 518
Hartley, Selwyn T. 572
Heard, John P. 459, 523
Holderfield, Hank 459
Hillis, Charles 437
Hillis, Mrs. Charles 437
Hobby, Mrs. A. Worth 517, 518
Hollis, Charles D., Jr., ... 487
Hoose, Mrs. Kenneth A., Jr. 515, 516
Huger, William E., Jr. 509
Jackson, Calvin 520
Johnson, Mrs. Ben, Sr. 516
Johnson, Milton I., Jr. 441, 499
Jones, Mrs. George R. 515, 517
Jordan, W. Dan 511
Katz, Mrs. Myron M. 515
Kaufmann, James A. 451, 503, 572
Lanford, Charles A. 493
Lanier, Robert G. 558
Lee, J. Moultrie 493
Logan, William D., Jr. 469, 569
Leslie, Mrs. John L. 518
Manning, Donald 471
Marks, Mrs. Thomas W. 517
McAlister, Bradwell R. 493
McDowell, Charles W., Jr. 451, 471
MCG Alumni 520
McKinnon, Frank W. 484
McLendon, Miriam 469, 494
McMichael, Mrs. Robert 518
Menendez, Jack F. 469, 528, 538
Merrill, Arthur P., Jr. 523
Moffett, James M. 469, 494
Molnar, E. M. 550, 558
Morris, A. J. 509
Nettles, Joseph L. 484
Palmer, E. Capers, Jr. 510
Parker, Dorothy 550
Patton, Mrs. Robert M. 515, 516
Phillips, Mrs. Hayward S. 517, 518
Prater, Mrs. Charles 436, 516
Prather, Stuart, Jr. 509
Quarterman, Keith A., Jr. 550
Raines, Jack A. 511, 523, 525, 558
Raitz, Mrs. Robert L. 515, 516
Rey, Charles J., Jr. 550
Richardson, Charles R. 545
Rogers, Harrison L., Jr. 465, 484, 558
Rowland, J. Roy 436
Satcher, David 437
Satcher, Mrs. Milton 516, 517
Scott, Mrs. James W. 515, 516
Sherman, Eloise 471, 472
Shumann, Wayne 572
Smith, Mrs. W. Jack 517
Spearman, W. Ben 558
Sullivan, James H. 436, 569
Storey, L. B. 509
Stubbs, Joe C. 558
Thibodeaux, Mrs. David C. 517
Turk, L. Newton, III 465, 503, 558, 568
Turner, J. R. 471
Vincent, Richard 539
Von Haam, Mrs. Emmerich 517
Waldemeyer, Mrs. E. W. 518
Walden, Mrs. Charles W. 517
Watson, John D., Jr. 436
Wells, David A. 520
Wells, Robert 471, 528
White, Mrs. Perry M. 517
Williams, Kenneth M. 471
Wilson, Frank L., Jr. 436, 503
Wolff, Mrs. Luther H. 517, 518
Wright, O. W. (''Bud'') 465

Classifieds

PHYSICIANS WANTED

MEDICAL DIRECTOR/DIRECTOR OF PROGRAM DEVELOPMENT — The Roosevelt-Warm Springs Institute for Rehabilitation is expanding its scope of services to include a 78-bed hospital, 20-bed Independent Living Unit, 225-bed vocational training program, research and training, recreation, and an adaptive living resource center. The new programs and substantial state support provide a rare opportunity for an innovative physician with some experience in rehabilitation. Low cost housing, mild climate, paid malpractice insurance, and excellent fringe benefits are an added incentive. Warm Springs is located 40 miles from Columbus and 70 miles from Atlanta. Salary negotiable. Send résumé to E. B. Dunlap, Jr., M.D., Acting Medical Director, RWSIR, Warm Springs, GA 31830. An equal opportunity employer.

FOR RENT

ROSWELL/GA 400 — Rapidly growing quality population center. New office and professional building still has 1,200 sq. ft. prime office off main entrance for physicians. Available immediately. Call owner at (404) 998-1688.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call (404) 634-1234.

ERRATUM: In the *Clinical Note* on Brucellosis that appeared on p. 371 of our May issue, Dr. Kenneth Alonso's name was misspelled in the list of authors. We are very sorry for this error.

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

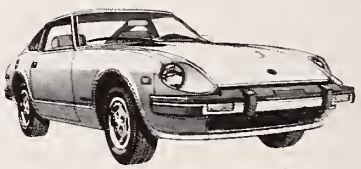
THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

MEDICAL MEETING CALENDAR

JUNE

12-14—*Jekyll Island;* **SELECTED TOPICS IN INTERNAL MEDICINE;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

16-17—*Augusta;* **THE TEACHING OF MEDICAL PROBLEM-SOLVING;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

18-19—*Louisville, KY;* **10TH ANNUAL KMA EMERGENCY MEDICAL CARE SEMINAR & 5TH ANNUAL EMERGENCY MEDICAL SERVICES CONFERENCE, DEPARTMENT FOR HUMAN RESOURCES;** Category 1 credit; Contact: Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, KY 40205. PH: 502/459-9790.

23-27—*Lake Buena Vista, FL;* **MKSAP-V (INTERNAL MEDICINE REVIEW, ACP);** Category 1 credit; Contact: Bill Rockwood, Coordinator, Box J-233, J. Hillis Miller Health Ctr., Univ. of Fla. College of Med., Office of CME, Gainesville, FL 32610. PH: 904/392-3143 or 392-3183.

26-28—*Hilton Head Island, SC;* **AMERICAN COLLEGE OF CHEST PHYSICIANS: CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND ASTHMA;** Category 1 credit; Contact: Thomas L. Petty, M.D., Chairman, Postgrad. Med. Ed. Committee, ACCP, P. O. Box 93826, Chicago, IL 60670. PH: 312/698-2220.

JULY

7-10; 14-16; 22-23—*Atlanta;* **THE FAMILY AND THE COMMUNITY: SUPPORT SYSTEMS & SERVICES FOR THE ELDERLY** (1980 Summer Series in Aging); Contact: Dr. Barbara Payne or Gordon Walker, Gerontology Ctr., Ga. State Univ., University Plaza, Atlanta 30303. PH: 404/658-2692.

8—*Birmingham, AL;* **SAFETY CLINIC;** Category 1 credit; Contact: Jim Hulett, Alabama Hospital Association, Box 17059, East Station, Montgomery, AL 36117. PH: 205/272-8781.

11-13—*Orlando, FL;* **CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION;** Category 1 credit; Contact: International Med. Ed. Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

12-19—*Mauna Kea Beach, HI;* **CARDIOVASCULAR MEDICINE AND SURGERY: AN ADVANCED COURSE;** Contact: Stanford Univ. Sch. of Med., Office of Postgrad. Med. Ed., Room TC129, Stanford, CA 94305.

19-25—*Atlanta;* **AMERICAN COLLEGE OF PHYSICIANS MKSAP V COURSE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St, SE, Atlanta, 30303. PH: 404/588-3534.

20-25—*Asheville, NC;* **SOUTHERN OBSTETRIC & GYNECOLOGIC SEMINAR;** Contact: G. T. Schneider, M.D., Ochsner Clinic, 1514 Jefferson Hwy., New Orleans, LA 70121.

22-26—*Hilton Head Island, SC;* **CONTEMPORARY CLINICAL NEUROLOGY;** Category 1 credit; Contact: Vanderbilt CME, 3200 West End, Suite 306, Nashville, TN 37203. PH: 615/322-2716.

27-30—*Hilton Head Island, SC;* **THIRD ANNUAL SYMPOSIUM: NUCLEAR CARDIOLOGY FOR THE PRACTICING PHYSICIAN;** Category 1 credit; Contact: J. S. Soin, M.D., Div. of Nuclear Med., Milwaukee County Medical Complex, 8700 W. Wisconsin Ave., Milwaukee, WI 53226. PH: 414/257-5968.

28-30—*Kiawah Island, SC;* **PEDIATRICS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

AUGUST

3-7—*Dallas, TX;* **NATIONAL MEDICAL ASSOCIATION 85TH ANNUAL CONVENTION;** Contact: National Medical Association, 1720 Massachusetts Ave,, NW, Washington, D. C.

4-8—*Atlanta;* **TAX, RETIREMENT, AND ESTATE PLANNING AND FINANCIAL INVESTMENTS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

5-8—*Atlanta;* **INTERNATIONAL CONFERENCE ON NOSOCOMIAL INFECTIONS;** Contact: R. E. Dixon, M.D., Hospital Infections Branch, Bacterial Diseases Div., Bureau of Epidemiology, CDC, 1600 Clifton Rd, NE, Atlanta 30333.

11-15—*Atlanta;* **INTERNAL MEDICINE BOARD REVIEW;** Category 1 credit; Contact: Daniel M. Smaw, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St, SE, Atlanta 30303. PH: 404/588-3525.

11-15—*Atlanta;* **RECENT ADVANCES IN INTERNAL MEDICINE;** Category 1 credit; Contact: Daniel M. Smaw, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St, SE, Atlanta 30303. PH: 404/588-3525.

21-22—*Birmingham, AL;* **SEMINAR ON QUALITY ASSURANCE;** Category 1 credit; Contact: Jim Hulett, Alabama Hospital Association, Box 17059, East Station, Montgomery, AL 36117. PH: 205/272-8781.

22-24—*Hilton Head, SC;* **CLINICAL MANAGEMENT OF CORONARY DISEASE AND EXERCISE TESTING;** Category 1 credit; Contact: International Med. Ed. Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

SEPTEMBER

18-20—*Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Contact: William C. McGarity, M.D., Secy.-Treas., Georgia Surgical Society, 1365 Clifton Rd, NE, Atlanta 30322.

27-30—*Kansas City, MO;* **CLINICAL DRUG THERAPIES (AMA);** Category 1 credit; Contact: Frank Chappell. PH: 312/751-6606 (Office) or 312/644-2426 (Home).

OCTOBER

6-9—*New Orleans, LA;* **32ND ANNUAL AAFP SCIENTIFIC ASSEMBLY.**

19-24—*Atlanta;* **CLINICAL CONGRESS, AMERICAN COLLEGE OF SURGEONS;** Contact: American College of Surgeons, 55 East Erie St., Chicago, IL 60611.

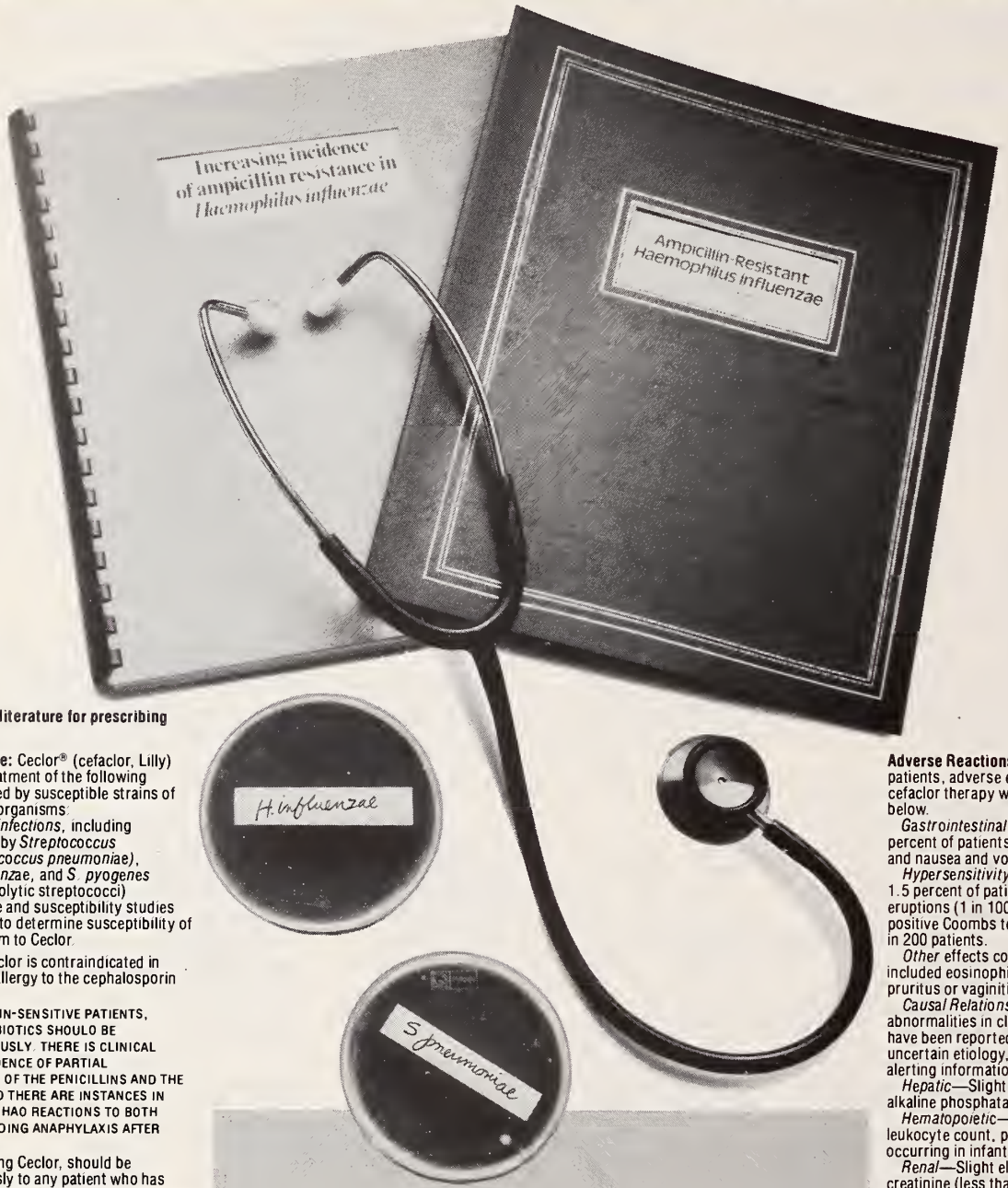
31-Nov. 2—*Callaway Gardens;* **PRE-PRACTICE SEMINAR;** Contact: Bert Franco, MAG, 938 Peachtree St, NE, Atlanta 30309. PH: 404/876-7535.

NOVEMBER

21-23—*Atlanta;* **MAG SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Stephen L. Daniel, MAG, 938 Peachtree St, NE, Atlanta 30309. PH: 404/876-7535.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

An added complication... in the treatment of bacterial bronchitis



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in abo 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genita pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve a alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allerg patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References
1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

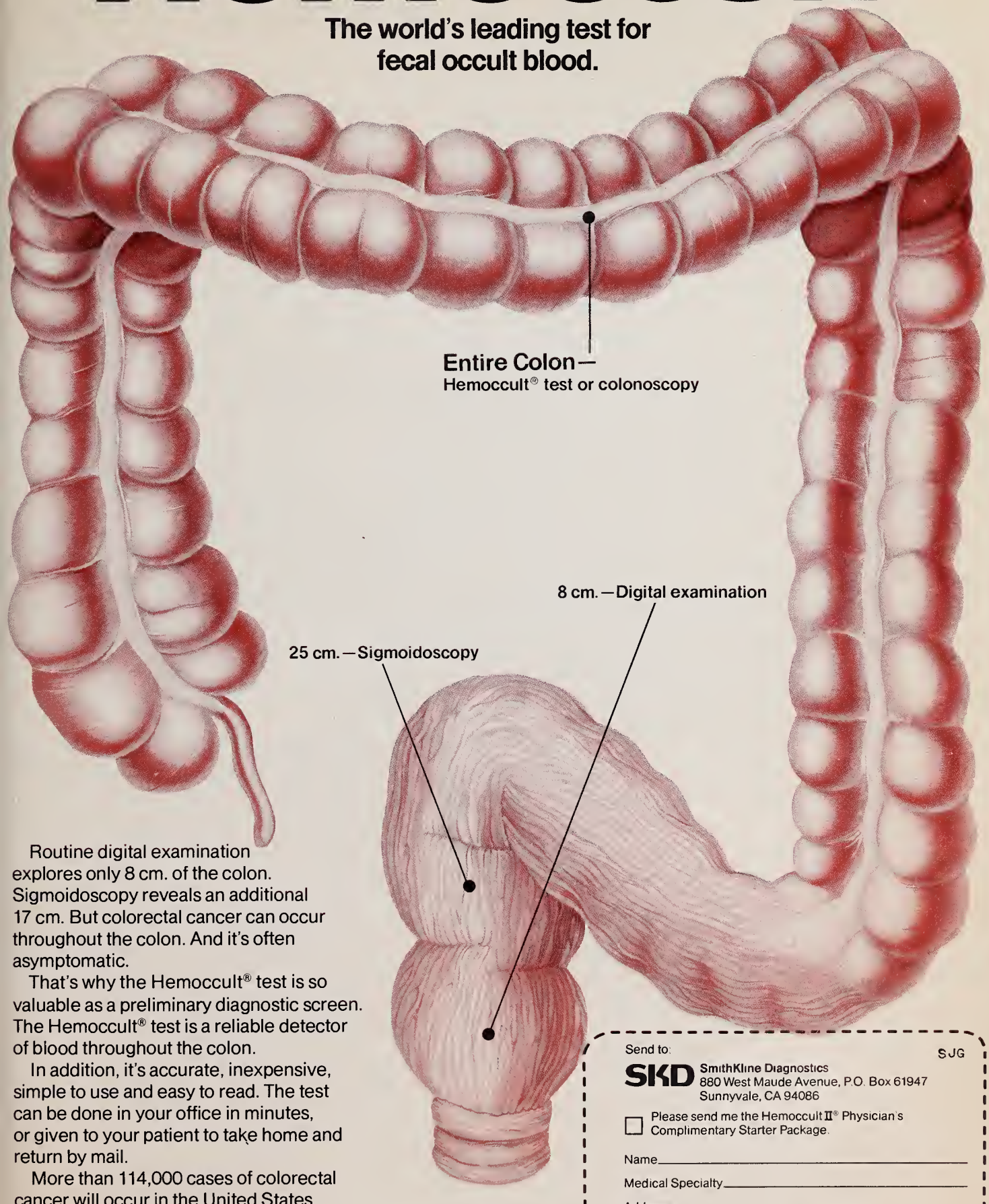
Lilly

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

000482

Hemoccult®

The world's leading test for fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult® test is so valuable as a preliminary diagnostic screen. The Hemoccult® test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 114,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult® starter package, today.

Send to: SJG

SKD SmithKline Diagnostics
880 West Maude Avenue, P.O. Box 61947
Sunnyvale, CA 94086

☐ Please send me the Hemoccult II® Physician's Complimentary Starter Package.

Name_____

Medical Specialty_____

Address_____

City_____ State_____ Zip_____

Phone_____

Hemoccult® is available through local distributors, nationwide.

© SmithKline Diagnostics, 1980

Perdiem empties the bowel gently...

by filling it.

Perdiem™ . . . the re-educative laxative
. . . relieves constipation by a unique combination o
physiological bulk stimulus and gentle pharmacologi
encouragement of peristaltic response

ROHER

WILLIAM H. RORER, IN
Fort Washington, PA 19034



Made in West Germany

(Please see next page for prescribing information)

Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

Not Only Seasons Change

Needs change. Lifestyles change. Sometimes opportunities don't meet expectations. Perhaps your professional environment no longer provides the challenge that's right for you. Or perhaps you and your family may be longing for an environment conducive to your free-time interests.

Times, places, opportunities change. We're specialists in change. Medseco consultant/placement specialists make a habit of matching the right physician with the right opportunity—be it a private or an Emergency Medicine practice. We can help you with your change. Talk to us now—in confidence—without cost, without obligation.

MEDSECO

Medical Search Consultants, Inc.
12605 East Freeway, Suite 608
Houston, Texas 77015
800 231-7888
713 451-2222(Texas)

MEDSECO

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

ONE



SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

CHOPPER ONE



CU 101



PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO

AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

— CALL TOLL FREE —

)RGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763



The Atlanta Hilton hosted the 1980 Annual Business Meeting.

Highlights of the 1980 Annual Session

The 1980 Annual Session of the Medical Associaton of Georgia (MAG) was held in Atlanta, Georgia, at the Atlanta Hilton Hotel April 24-27, 1980. There were 373 persons in attendance, including Delegates, Alternate Delegates, members, auxiliary, and guests. Forty-eight county medical societies were represented at this session.

Hoyt D. Gardner, M.D., president of the American Medical Association, addressed the House on Saturday morning. H. Hilt Hammett Jr., M.D., president-elect of MAG, addressed the House on Sunday morning.

Highlights of the 1980 House of Delegates are presented here. A detailed report of the proceedings follows.

Awards

The 1980 Family Physician of the Year Award was presented to Charles L. Hillis, of LaFayette.

For his contributions to the general public through his participation in civic affairs, John D. Watson Jr., of Columbus, received this year's Civic Endeavor Award.

The recipient of the Distinguished Service Award was J. Roy Rowland Jr., of Albany.

The *Journal of the MAG* won 1st place in a national competition among state medical journals sponsored by Sandoz Pharmaceuticals.

Nursing

The House adopted the following definition of supervison of nurses: "Physician supervision of a nurse means that he is responsible for the medical acts performed by the nurse, acting in accordance with his prescription or instruction. The supervising physician or physician designee must be available daily to examine his patient and must regularly and systematically review the medical care."

Podiatry

The House adopted a new policy statement on podiatry which recognizes that a podiatrist "by training, experience, and statute is a limited practitioner . . . and that decisions regarding staff privileges and use of in-hospital medical facilities by limited licensed practitioners" should be made by hospitals. The House further agreed to support the "right of a hospital to deny staff privileges to a class of limited health care practitioners who are licensed by the state, so long as such exclusion has a rational basis and is reasonably related to the operation of a hospital."

Medical Schools

The House adopted a resolution (1) supporting increased state funding for the Medical College of Georgia:

(2) supporting increased capitation funding for Emory University School of Medicine and the School of Medicine at Morehouse College; and (3) opposing an increase in enrollment of medical students at the Medical College of Georgia and the development of other medical schools in the state until support for existing schools with students enrolled is assured.

Physicians' Assistants

The House adopted an "MAG position statement on Physicians' Assistants" (PAs), directed the Executive Committee to appoint a delegation to present this position to those in the medical colleges responsible for the PA training programs, and requested the MAG Committee on PAs continue to monitor the development and activities of the PAs and their employing physicians. (The position statement appears in its entirety in this issue.)

AMA

The House directed MAG's AMA Delegation to submit to the AMA House a resolution which would change the procedure for electing AMA presidents to a direct-mail ballot to be sent to all AMA members and establish a 2-year term with the right of succession of two additional 2-year terms.

Medical Practice

The House charged the Medical Practice Committee to persevere in its efforts to monitor the developments and quality of care provided in the federally and state-funded rural and/or urban clinics. Each county medical society will be requested to take specific actions to assist in determining the physicians' availability, type of procedure conducted, cost of services, and qualifications of individuals providing care in each of the clinics within its geographic boundaries.

Insurance

The House endorsed the concept that the physician should be reimbursed for out-patient as well as in-patient services provided that the rendering of such services be at the discretion of the patient and the attending physician.

MAG Budget

The House adopted a budget of $1,375,718 for the fiscal year 1980-81 (June 1 to May 31). The House also approved a recommendation that the Sinking Fund for land acquisition be changed to Building and Renovation. This will enable the Board of Directors to spend these funds to improve the present MAG Headquarters and enlarge the building if and when necessary.

Dues

The House approved the recommendation that there should be no dues increase until the liquid unrestricted funds of the Association are reduced to one-half the amount budgeted for expenses each year and that these funds be spent only by recommendation of the Finance Committee and the Board of Directors.

Marijuana

The House adopted as policy that MAG support the use of marijuana in a strictly controlled medical research program for cancer or glaucoma patients but strongly condemns its use for other purposes.

HMOs

The House adopted an MAG position statement on Health Maintenance Organizations (HMOs) which is included in this issue. The House also voted to "go on record as disapproving federal and state support of any one type of health care delivery system over another."

Prescriptions

The House adopted a resolution requesting MAG members to write prescriptions for a specified length of time and requesting pharmacists not to refill prescriptions past the time marked on the prescription.

Medicaid

The House directed the Committee on Third Party Relations to continue to revise the Physicians' Medicaid Provider Manual and asked the MAG membership to inform the committee of its problems with this manual. The House further adopted a resolution that MAG increase as necessary its efforts to assist members in resolving problems with Medicaid and that a study be undertaken to determine the extent to which Medicaid reimbursement is untimely and insufficient.

National Catastrophic Health Insurance

The House reaffirmed MAG's position opposing federally mandated and controlled catastrophic health insurance and directed that this opposition be communicated to Georgia's representatives.

Practice what we teach

Today there are over 31 million men, women and children suffering from the many forms of arthritis and related rheumatic diseases. And there just aren't enough trained rheumatologists to help them.

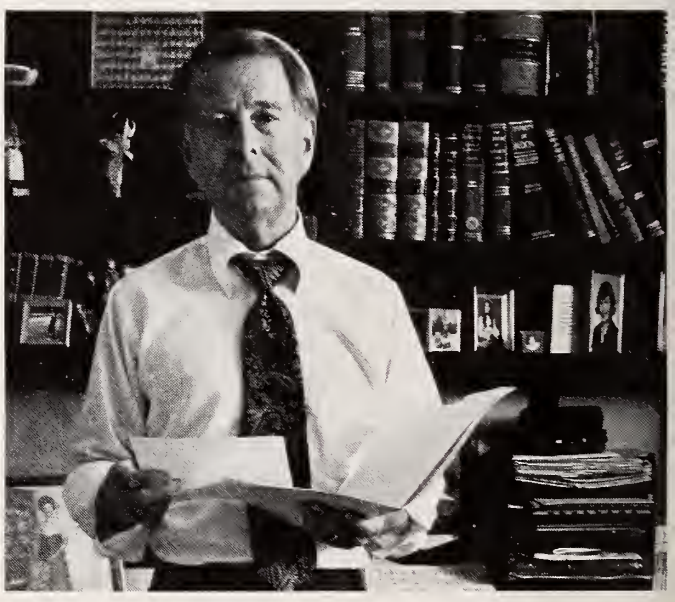
That's why arthritis sufferers need your help.

They must depend heavily on the family practitioner for better diagnosis, more effective patient treatment.

Contact your local Arthritis Foundation chapter for the latest information on arthritis. This includes continuing educational seminars by leading rheumatologists, scientific meetings, "outreach" programs—as well as the "Bulletin on the Rheumatic Diseases," "Arthritis and Rheumatism Journal," "Primer on the Rheumatic Diseases," audio cassettes and other professional materials. Free disease handbooks and medication pamphlets are also available to patients.

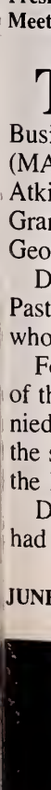
Please. Let us help your practice with what we teach.

The Arthritis Foundation helps doctors help.



ARTHRITIS FOUNDATION

A public service of this magazine.



President
Meeting of

THE
Business
(MAG) w
Atkins,
Grand Sa
Georgia.

Dr. At
Pastor of
who deli

For the
of the M
nied by M
the singi
the Pledg

Dr. At
had died



Frank L. Wilson, Jr., President of the Medical Association of Atlanta, extended greetings to the assembly from the host county medical society.



President-Elect of the Southern Medical Association Auxiliary, Mrs. Charles Prater of Jellico, Tennessee, addresses the House of Delegates at its opening ceremonies. Also shown are (L-R) Mrs. Michel Glucksman, President of the A-MAG, Earnest Atkins, James Sullivan, and L. C. Buchanan.

extended official greetings to the assembly from the host county medical society.

Introduction of Distinguished Guests

Dr. Atkins introduced Mrs. Irene Glucksman of Brunswick, President of the Auxiliary to the MAG. Mrs. Glucksman gave a brief report on the activities of the Auxiliary during the past year and introduced special guests, Mrs. Ben Johnson Jr., of Bessimer, Alabama, President of the Auxiliary to the American Medical Association (AMA); and Mrs. Charles Prater of Jellico, Tennessee, President-Elect of the Southern Medical Association Auxiliary. Mrs. Johnson and Mrs. Prater each brought greetings from their respective organizations.

Civic Endeavor Award

Dr. Atkins called on President-Elect H. Hilt Hammett, Jr., M.D. of LaGrange to present the 1980 MAG Civic Endeavor Award to John D. Watson, M.D., of Columbus.

Distinguished Service Award

Dr. Hammett also presented the Distinguished Service Award to J. Roy Rowland, M.D., of Dublin, Georgia.

Family Physician of the Year Award

Dr. Atkins then called on Dr. Robert A. Pumpelly, President of the Georgia Academy of Family Physicians, who presented the Family Physician of the Year Award to Charles L. Hillis, M.D., of LaFayette, Georgia.

Sandoz Journalism Award

The Sandoz Pharmaceutical Company, having previously elected the *Journal of the Medical Association of Georgia* as the Outstanding State Medical Journal in the nation, presented a special award at this time. Edgar Woody Jr., M.D., Editor of the *Journal of the MAG* accepted the award.



John D. Watson, Jr., Columbus, was the 1980 recipient of the Civic Endeavor Award.

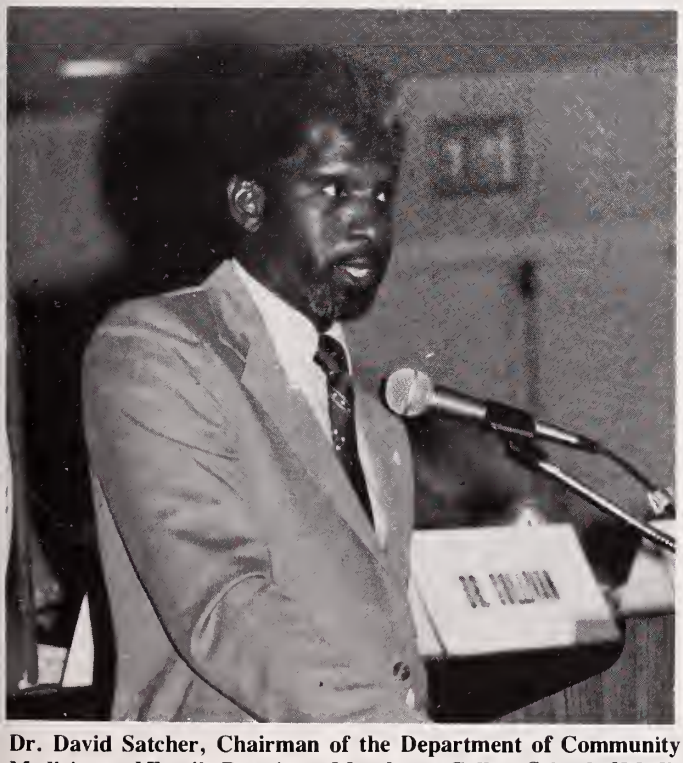


Georgia Representative J. Roy Rowland, M.D., of Dublin, received this year's Distinguished Service Award.



Forrest Rogers — *Lafayette Gazette*

Dr. and Mrs. Charles Hillis from LaFayette. Dr. Hillis was this year's recipient of the "Family Physician of the Year Award."



Dr. David Satcher, Chairman of the Department of Community Medicine and Family Practice at Morehouse College School of Medicine, expresses his appreciation for the AMA-ERF check which was presented to the school.

Certificates of Appreciation

William D. Logan Jr., M.D., Secretary, announced that Certificates of Appreciation were awarded to: Joseph M. Almand, LaGrange; Earnest C. Atkins, Decatur; J. Norman Berry, Atlanta; Mrs. Lola Inman Brown, Atlanta; L. C. Buchanan, Decatur; F. G. Eldridge, Valdosta; Representative Dorothy Felton, Atlanta; Michel A. Glucksman, Brunswick; Mrs. Irene Glucksman, Brunswick; W. Carl Gordon Jr., Albany; Senator Richard L. Greene, Macon; Richard A. Griffin III, Cartersville; W. Dan Jordan, Atlanta; Senator E. Culver Kidd, Milledgeville; Mark M. Lindsey, Atlanta; D. R. Mahan Jr., Dalton; Jack F. Menendez, Macon; Jack A. Raines, Columbus; M. Virlyn Slaton, Atlanta; and Joe C. Stubbs, Valdosta.



The singleness of purpose and the determination of our new President, H. Hilt Hammett, Jr., M.D., can only indicate a positive presage for the MAG in the coming year.

Fifty-Year Certificates

Dr. Atkins then announced that the recipients of the Fifty-Year Certificates and Pins would be: Dave Berman, Columbus; Clyde L. Crawford, Atlanta; O. D. Gilliam, Columbus; B. Lester Harbin, Rome; Herschel B. Harris, Watkinsville; A. G. Hendrick, Perry; James C. Holder, LaGrange; Oliver W. Jenkins, Lyndale; William F. Jenkins, Columbus; McClaren Johnson, Atlanta; Robert M. Joiner, Moultrie; J. R. S. Mays, Macon; Walter P. Rhyne, Albany; Thomas L. Ross, Jr., Macon; S. B. Traylor, Barnesville; Exum B. Walker, Atlanta.

Life Members

Dr. Atkins then announced that the following members have been awarded life membership in MAG: Gabriel G. Del Rio, Savannah; Franklin D. Edwards, Columbus; Davis B. Fillingim, Savannah; G. Steadman Glisson Jr., Atlanta; John E. Gregory, Columbus; James F. Hackney, Atlanta; William N. Harper, Atlanta; Allen E. Hauck, Atlanta; Stephen J. Lange Sr., Savannah; Marvin A. Mitchell, Atlanta; William S. Odom, Columbus; Miechzslaw Peszczynski, Atlanta; John E. Porter, Savannah; Harry J. Portman, Savannah; Edna S. Porth, Atlanta; Arthur M. Pruce, Atlanta; Charles T. Rumble, Forsyth; Cyrus W. Strickler Jr., Atlanta; Trawick H. Stubbs, Decatur; John Van Duyn, Columbus; Bernard P. Wolff, Decatur.



Joseph P. Bailey, M.D., from Augusta speaks to the House of Delegates about the Medical College of Georgia and thanks the MAG for the grant monies.



As Drs. Earnest Atkins (L) and L. C. Buchanan look on, James A. Bain, Ph.D., from Emory University School of Medicine approaches the podium to receive an AMA-ERF check.

AMA-ERF Checks

Dr. Atkins presented the three Georgia medical schools unrestricted grant monies in the form of AMA-ERF checks raised by contributions from the physicians and the Auxiliary during the previous year. Dr. Atkins presented checks as follows: to the Medical College of Georgia, a check in the amount of $6,820.46; to Emory University School of Medicine, a check in the amount of $9,239.06; and to the School of Medicine at Morehouse College, a check in the amount of $525.00.

Membership Recruitment Film

Dr. Atkins presented a special membership recruitment film entitled "What is the AMA? The AMA is You!" Dr. Atkins announced that the film is available for loan to anyone wishing to use it for membership recruitment purposes either at county medical society meetings or at meetings of hospital medical staff.

Following several brief announcements, Dr. Atkins adjourned the First General Session at 8:30 PM.

Introducing...

TEGA-CORT FORTÉ 1% - TEGA - CORT - 0.5%

(Available at all drug stores - Rx Only)

SQUEEZE TYPE DISPENSER BOTTLES

Tega-Cort Forté and **Tega-Cort** lotions are offered in a nice smooth non-staining water soluble base.

Indications: For relief of the inflammatory manifestations of corticosteroiid responsive dermatoses including Poison Ivy, and sunburn.

Contraindications: Topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, or in large amounts, or for prolonged periods of time.

Dosage and Administration: Apply to affected area 3 or 4 times daily as directed by your physician.

Caution: Federal law prohibits dispensing without prescription. For external use only. Store in a cool place but do not freeze.

PLEASE CONSULT INSERT SUPPLIED WITH EACH BOTTLE FOR MORE DETAILED INFORMATION

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

REG. NO.

THE DEVEREUX FOUNDATION

ARIZONA
CALIFORNIA
CONNECTICUT
GEORGIA

PENNSYLVANIA

MASSACHUSETTS
TEXAS
ARKANSAS

M

DATE

Rx

Age Pre-Adolescents Adolescents & Young Adults

HEDGES TREATMENT CENTER

Intensive psychiatric care for youths and young adults in transition, those who are not fully ready to utilize a conventional residential treatment approach but whose problems are not severe enough to warrant psychiatric hospital attention.

M.D.

Rx

Age 17-24

CAREER HOUSE

For intellectually bright high school graduating seniors, and post-high school youth with problems of underachievement and/or personal adjustment. Psychotherapy, academic and vocational counseling. Arrangements made for enrollment in local colleges and career schools.

M.D.

Rx

Age Under 10

CENTER FOR AUTISTIC AND SCHIZOPHRENIC CHILDREN

A comprehensive, short-term, residential treatment program for severely disturbed children under ten years of age.

M.D.

Rx

Age Adolescents and Adults

EDWARD L. FRENCH REHABILITATION CENTER

C. A. R. F. Approved

Residential and day programs. Comprehensive vocational evaluation, training and placement services. Opportunities for social adjustment training, work adjustment training, and sheltered employment.

M.D.

. . . And many more separate day and residential treatment programs **prescriptively planned** for children and young adults with emotional and mental disabilities

Helena T. Devereux
Founder

Joseph B. Ferdinand
President

Charles J. Fowler
National Director of Admissions

FOR INFORMATION AND LITERATURE:

PENNSYLVANIA Ellwood M. Smith, Admissions Director, Devon, Pa. 19333 or call 215 687-3000
CALIFORNIA Keith A. Seaton, Admissions Director, Box 1079 Santa Barbara 93102or call 805 968-2525
TEXAS Robert E. Worsley, Admissions Director, Box 2666, Victoria 77901 or call 512 575-8271
ARIZONA Richard A. Etter, Director, 6436 E. Sweetwater, Scottsdale 85254 or call 602 948-5857
GEORGIA Ralph L. Comerford, Director, 1980 Stanley Road, N. W., Kennesaw 30144 or call 404 427-0147
CONNECTICUT Theodore E. Enoch, Director, Sabbaday Lane, Washington 06793 or call 203 868-7377
MASSACHUSETTS Frederic A. Hervey, Director, Miles Road, Rutland 01543 or call 617 886-4746

. . . Carrying the Promise of Happy Tomorrows



THE DEVEREUX FOUNDATION

A NONPROFIT ORGANIZATION

All Devereux Branches Surveyed by the Joint Commission on Accreditation of Hospitals are Approved as Psychiatric Facilities for Children and Adolescents

We're not asking you for money.

Just a few words. To people who need us but don't know we exist.

We're Recording for the Blind. We're already helping more than 13,000 handicapped students. But there are a lot more out there who need our help.

You know who they are. In your work you come across students who are blind, dyslexic or physically unable to handle books. These are the students we help. Since they cannot read their textbooks, we do it for them. On tape. And we send the tapes to the students free of charge.

All we want you to do is tell eligible students about us. Have them contact: Student Services, RFB, Inc., 215 East 58th Street, N.Y., N.Y. 10022, (212) 751-0860. We'll take it from there.

It's such a little thing to ask.

Recording for the Blind is a non-profit organization. All contributions are tax-deductible.

Recording for the Blind, Inc.

an educational lifeline.



Delegates attend to the instruction of Speaker Buchanan. Past President Milton Johnson, Jr., from Macon is on the far right.

126th MAG House of Delegates
First Session
Thursday, April 24

THE FIRST SESSION of the MAG House of Delegates was called to order by the Speaker, L. C. Buchanan, M.D., at 8:35 PM, Thursday, April 24, 1980, in the Grand Salon East of the Atlanta Hilton Hotel, Atlanta, Georgia.

The Speaker extended greetings to all delegates and briefly outlined the responsibilities of the House and the procedure to be followed during the 4-day Session of the House between April 24-27, 1980.

The Speaker called for a report from the Credentials Committee regarding delegates in attendance. Virgil McEver reported that 125 Delegates were present, and accordingly, announced that a quorum of the House was present.

ATTENDANCE

Delegates: Donald C. Abele, Stanley P. Aldridge, Julian Duttera, Patrick L. Anders, Thomas J. Anderson, McAlpin H. Arnold, Phil C. Astin, John F. Atha, Sam O. Atkins, Ann A. Bailey, Joseph P. Bailey, J. Dan Bateman, John G. Bates, Linton H. Bishop, H. Duane Blair, Allan C. Bleich, Claud A. Boyd Jr., D. Morton Boyette, Stephen Boyles, Rupert H. Bramblett, Spencer S. Brewer Jr., L. C. Buchanan, E. Napier Burson Jr., Ted D. Cash, George Chastain, William E. Mayher, Joseph T. Christmas, S. William Clark Jr., Marvyn D. Cohen, Richard W. Cohen, William C. Collins, Lanny R. Copeland, A. J. Crumbley Jr., Leon E. Curry, David E. Dalrymple, John W. Darden, Floyd E. Davis, H. G. Davis Jr., R. Carter Davis Jr., J. H. Deaton, Sammie Dixon, Leon Bush, F. William Dowda, Richard E. Dubois, S. Boyd Eaton, E. C. Evans, Louis H. Felder, Edgar J. Filson, Milton Frank III, Whitman Fraser, James Freeman, David J. Frolich, Norman P. Gardner, Cyler D. Garner, E. W. Holloway Jr., Robert G. Bradbury, Joseph L. Girardeau, Michel A. Glucksman, Joe L. Griffeth, Richard A. Griffin III, H. Hilt Hammett Jr., Carl V. Hancock Jr., William R. Hardcastle, Charles E. Harrison Jr., J. Harold Harrison, John P. Heard, Armand E. Hendee, Jesse D. Hester, Charles L. Hillis, Hugh O. Hodges, William E. Holladay Jr., Charles D. Hollis Jr., Ralph D. Hopkins, William Huger Jr., Gerald Sanders, Joseph M. Jackson, William C. T. Jernigan, C. E. Johnson Jr., Jimpsey B. Johnson,

Julius T. Johnson, R. Lanier Jones, W. Dan Jordan, James A. Kaufmann, Robert E. Kelley Jr., Spencer B. King, III, Luella M. Klein, Robert M. Patton, C. Peter Lampros, Charles A. Lanford, Bob G. Lanier, J. Moultrie Lee, J. Robert Logan, William D. Logan Jr., C. G. Magnan Jr., Donald H. Manning, Betty Wray, Joe B. Massey, Bob R. Maughon, Stephen C. May Jr., Alva Louie Mayes Jr., Edwin A. Mayo, Bradwell R. McAlister, J. Kenneth McDonald, Charles W. McDowell Jr., V. W. McEver, Lamar S. McGinnis Jr., Frank W. McKinnon, Jack F. Menendez, Arthur J. Merrill Jr., Jerry Muller, Cecil L. Miller, Edmund M. Molnar, W. W. Moore, Toby S. Morgan, A. J. Morris, R. J. Moye, S. Patrick Evans, Spencer G. Mullins, A. D. Muse Jr., Joe L. Nettles, Bruce C. Newsom, John S. Newton, Jeffrey T. Nugent, James L. O'Quinn, J. Gary Palmer Jr., Thomas Nelson Kias, Harry Porter Jr., Stuart H. Prather Jr., Quentin Price, Robert A. Pumpelly, Keith A. Quarterman Jr., Jack A. Raines, Samuel Dean Rauch, Walker L. Ray, James Walker, Charles J. Rey Jr., Charles R. Richardson, H. Dale Richardson, Wells Riley, Harrison L. Rogers Jr., Clyde B. Rountree, Beverly B. Sanders Jr., W. Michael Bailey, T. A. Sappington, J. K. Schellack, Romero M. Sealey, Charlie O. Sennett Jr., Eloise B. Sherman, Barry D. Silverman, Robert W. Simmons, James M. Skinner, T. G. Smaha, W. T. Smith, William B. Spearman, Herman E. Spivey, Dan B. Stephens, Marvin R. Stephens, Joe C. Stubbs, O. Wytch Stubbs Jr., James H. Sullivan, Robert F. Sullivan, Roland S. Summers, William A. Wolff, Ernest E. Pierleoni, Luther M. Thomas Jr., Thomas L. Tidmore Jr., Ralph A. Tillman, Charles E. Todd Jr., L. Newton Turk III, J. R. Turner, Charles R. Underwood, Hugo Moreno, R. D. Walter, Alexander H. S. Weaver, H. E. Weems Jr., Robert E. Wells, Walter S. Gresham, William H. Whaley, Theodore C. Whitson, Dan H. Willoughby, Frank L. Wilson Jr., O. Emerson Ham, John Thomas Yauger, Neal F. Yeomans.

Alternate Delegates: James Asbell, William M. Bailey, C. Emory Bohler, H. Hutson Carspecken, Chappell A. Collins Jr., William T. Ayers, H. R. Foster, Tom A. Cochran, William H. Hayes, William McKendree Headley, Kenneth C. Henderson, Emory W. Holloway Jr., Georgia B. Hubbard Jr., Milton I. Johnson, Jr., James C. Joiner, George R. Jones, Thomas M. Mahon, Richard C. Mattison, James Suit, Ray L. McKinney, Alex R. Mitchell, Hugo S. Moreno, E. Capers Palmer Jr., Alexander T. Parkinson, J. Roy Rowland Jr., James A. Walker, William A. Wolff.

Speaker Buchanan thanked the Chairman of the Credentials Committee and then presented the Vice Speaker, Jack Menendez, M.D., of Macon to the Assembly.

(Editorial note: Those names that are not in alphabetical order in either of these lists represent those who filled in for delegates or alternates who were unable to attend.)

APPOINTMENT OF COMMITTEES

The Speaker announced the appointment of the House of Delegates Reference Committees, Credential Committee, and Tellers Committee as follows:

Reference Committee A: Eloise Sherman, Savannah, Chairman; Robert Wells, Atlanta, Vice-Chairman; Charles McDowell, Decatur; J. R. Turner, LaGrange; Donald Manning, Brunswick; Sammie Dixon, Tifton.

Reference Committee B: Jack A. Raines, Columbus, Chairman; John P. Heard, Decatur, Vice-Chairman; Harry Porter, Jr., Marietta; Arthur P. Merrill Jr., Atlanta; Morton D. Boyette, Albany; Jimpsey B. Johnson, Augusta.

Reference Committee C: Ronald F. Galloway, Augusta, Chairman; Edmund M. Molnar, Columbus, Vice-Chairman; Keith A. Quarterman Jr., Atlanta; Charles R. Richardson, Statesboro; John F. Atha, Rockmart; Charles J. Rey Jr., Austell.

Reference Committee D: Spencer S. Brewer Jr., Atlanta, Chairman; J. Moultrie Lee, Savannah, Vice-Chairman; Alva Louie Mayes Jr., Macon; Charles A. Lanford, Macon; Bradwell R. McAlister, Gainesville; McAlpin H. Arnold, Elberton.

Reference Committee F: H. Duane Blair, Decatur, Chairman; Cyler D. Garner, Gordon, Vice-Chairman; Stuart Prather Jr., Augusta; William Huger Jr., Atlanta; William R. Hardcastle, Tucker; A. J. Morris, Vidalia.

Tellers Committee: T. A. Sappington, Thomaston, Chairman; Claud Boyd Jr., Augusta; Joseph T. Christmas, Vienna; Milton I. Johnson, Macon.

Credentials Committee: A. D. Muse, Athens, Chairman; Virgil McEver, Warner Robins.

ADOPTION OF MINUTES

The Speaker announced that the Proceedings of 1979 Annual Session had been published in the July 1979 issue of the *Journal of the MAG* and called for any corrections that should be made.

On motion duly made and seconded, it was voted that the Proceedings of the 1979 Meeting as published in the July issue of the *JMAG*, be approved as published.

NOMINATIONS

Speaker Buchanan called on the House to proceed with nominations of the Officers, AMA Delegates and Alternates, Directors and Alternate Directors. He reminded the House that the election would be held on Sunday morning between the hours of 7-9 AM and that ballots would be provided by the Tellers Committee at the polling booth. The Speaker asked for nominations for the Office of the MAG President-Elect and the following nomination was made:

President-Elect: L. Newton Turk III, Atlanta, was nominated by Frank Wilson Jr., Atlanta. Dr. Turk's candidacy was seconded by Joe Nettles, Lamar McGinnis, J. Dan Bateman, and Joe Stubbs. There being no further nominations for the office of president-elect, the nominations were closed.

Second Vice-President: William C. Collins, Atlanta, was nominated by W. Ben Spearman, Atlanta. Dr. Collins' candidacy was seconded by Alex Weaver, James Sullivan, Charles Hollis, Carson Burgstiner, and Cecil Miller. There being no further nominations for the office of second vice-president, the nominations were closed.

Speaker of the House: Jack F. Menendez, Macon, was

nominated by Charles Magnan, Macon. Dr. Menendez's candidacy was seconded by Milton Johnson, Michel Glucksman, Carson Burgstiner, Rupert Bramblett, William D. Logan, and Charles Hollis.

Vice-Speaker of the House: James A. Kaufmann, Atlanta, was nominated by Frank Wilson, Atlanta. Dr. Kaufmann's candidacy was seconded by S. W. Clark, Earnest C. Atkins, Jack Raines, Dan Willoughby, Joe Bailey, Charles Hollis, Wycht Stubbs, Jr., Beverly Sanders, Stephen May, and Richard Griffin III.

AMA Delegate: Speaker Buchanan called for nominations for Delegates and Alternate Delegates to the AMA, observing that the term of all new Delegates and Alternates would begin on Jan. 1, 1981.

For the AMA Delegate's seat currently held by Harrison L. Rogers Jr., Atlanta, Dr. Rogers was nominated by F. William Dowda, Atlanta, and seconded by Joe Stubbs and Frank Wilson Jr.

For the AMA Delegate seat currently held by J. Dan Bateman, Albany, Dr. Bateman was nominated by Charles Hollis and seconded by Harrison L. Rogers. There being no further nominations for the position of AMA Delegate, nominations were closed.

AMA Alternate: For the AMA Alternate seat currently held by H. Hilt Hammett Jr., LaGrange, Dr. Hammett was nominated by Julian Duttera, LaGrange. Dr. Hammett's candidacy was seconded by Earnest C. Atkins, T. A. Sappington, Milton I. Johnson, and F. William Dowda.

For the AMA Alternate seat currently held by William W. Moore, Atlanta, Dr. Moore was nominated by J. Harold Harrison and seconded by Jack Raines. There being no further nominations for the AMA Alternate Delegate, the nominations were closed.

SIXTH DISTRICT DIRECTOR AND ALTERNATE DIRECTOR

Speaker Buchanan announced that the Sixth District Medical Society had failed to elect its Director and Alternate Director to the MAG Board and, therefore, in accordance with Chapter VI, Section 3, of the MAG Bylaws, it was the responsibility of the House of Delegates to elect a Director and Alternate Director from the Sixth District. He then called for nominations for these posts.



Delegate Dan Bateman again serves his district and organized medicine at this Session.

Director: James Skinner, Griffin, was nominated for Sixth District Director by T. A. Sappington, Thomaston.

Alternate Director: Norman P. Garner, Thomaston, was nominated by T. A. Sappington, Thomaston.

There being no further nominations for the position of Director and Alternate Director from the Sixth District, the nominations were closed.

DIRECTORS AND ALTERNATE DIRECTORS

Dr. Buchanan announced the results of the election for Directors and Alternate Directors as conducted by the Component Medical Societies:

Second District Director: Sammie Dixon, Tifton (1982). Alternate Director: Lanny Copeland, Moultrie (1982).

Eighth District Director: Joe C. Stubbs, Valdosta, (1983). Alternate Director: Michel A. Glucksman, Brunswick, (1983).

Dougherty County Medical Society: Director: J. Dan Bateman, Albany, (1983). Alternate Director: Frank F. Middleton III, Albany, (1983).

Hall County Medical Society: Director: Henry Jennings, Gainesville, (1983). Alternate Director: John Reed, Gainesville, (1983).

Medical Association of Atlanta: Director: William C. Collins, Atlanta, (1983). Alternate Director: Bob G. Lanier, Atlanta, (1983).

Muscogee County Medical Society: Director: Jack A. Raines, Columbus, (1983). Alternate Director: E. M. Molnar, Columbus, (1983).

ANNUAL REPORTS

Delegate Richard Dubois, Atlanta, advised the House that the attachments to the report of the *Ad Hoc* Committee on Medical Ethics were not to be considered as a part of the committee report and moved that these attachments not be printed in the Proceedings Issue of the MAG *Journal*. This was accepted by the Chair and the House.

Delegate James Sullivan of Columbus moved to refer the report of the Committee on Peer Review and accordingly, the Speaker referred this report to Reference Committee D.

Speaker Buchanan called for the annual reports of the MAG officers, directors, committees, departments, and other reports to be introduced at this session which are listed below with the reference committee to which these reports were referred. (Editorial Note: Each complete report, the recommendation of the Reference Committee, and the subsequent action taken by the House of Delegates on all reports referred to Reference Committees, will be found under the proceedings of the Second Session and the Third Session of the House of Delegates.)

Officers' Reports

President — Recommendations 1, 2, 4, 6 — A
Recommendations 3, 5 — F
First Vice-President — Not Referred
Chairman of the Board — A
Secretary — Not Referred
Treasurer — F
Speaker — A
Vice-Speaker — C

Directors' Reports
AMA Delegation — A
First District Medical Society — Not Referred
Second District Medical Society — Not Referred
Third District Medical Society — Not Referred
Sixth District Medical Society — Not Referred
Seventh District Medical Society — Not Referred
Eighth District Medical Society — Not Referred
Ninth District Medical Society — Not Referred
Tenth District Medical Society — Not Referred
Bibb County Medical Society — Not Referred
Cobb County Medical Society — Not Referred
DeKalb County Medical Society — Not Referred
Floyd-Polk-Chatooga Medical Society — Not Referred
Georgia Medical Society — Not Referred
Medical Association of Atlanta — Not Referred
Muscogee County Medical Society — Not Referred
Richmond County Medical Society — Not Referred

Committee Reports
Access to Health Care — D
Auxiliary — Not Referred
Cancer — D
Composite State Board of Medical Examiners — Not Referred
Constitution and Bylaws — A
Constitution and Bylaws Supplemental — A
Cost Awareness — Not Referred
Education — D
Education Supplemental — D
Emergency Medical Services — C
Health Planning — D
Legislation — Not Referred
Maternal and Infant Health — Not Referred
Medical Aspects of Sports — Not Referred
Medical Practice — A
Medical Practice Supplemental — A
Medicine and Human Values — Not Referred
Membership — A
Mental Health — Not Referred
Nursing — B
Nutrition — D
Occupational Health — Not Referred
Peer Review — D
Physicians' Assistants — B
Physician Consultants to Disabled Doctors Program — A
Prison Health Care — Not Referred
Public Health — C
Public Relations — B
Scientific Assembly — Not Referred
Third Party Relations — C
Third Party Relations Supplemental — C
Truthful Advertising — Not Referred
Women Physicians in Organized Medicine — Not Referred
Physician/Lawyer Liaison — Not Referred
Ad Hoc – Drugs — Not Referred
Ad Hoc – Principles of Medical Ethics — C
Ad Hoc – Risk Management — Not Referred
Supplemental Report of Cancer — D
Georgia Chapter AAMA — Special Report — D

Department Reports
Georgia Medical Care Foundation — Not Referred
Journal of the Medical Association of Georgia — Not Referred



MAG's Immediate Past First Vice-President Richard A. Griffin, III, from Cartersville.

The Speaker called attention to the reports which are shown as having no recommendations and thus have not been referred to any Reference Committee. He advised further that several reports without recommendations had been referred at the request of Delegates and, accordingly, these had been referred to a Reference Committee.

The Speaker then announced that all reports not referred to a Reference Committee would be filed for information. They are as follows:

FIRST VICE-PRESIDENT

Richard A. Griffin, III, M.D., F.A.C.S.

Included in the report of the First Vice-President, I would like to address some issues that are abrasive to the practicing physicians that certainly aren't necessary but are very likely to worsen before they improve. The issue that has been most prevalent on my mind for the last couple of years, while I have served as your Vice-President, has been that of the rapid deterioration of nursing education. The American Nurses Association (ANA) seems to be the leader of an effort to basically require closure of diploma nursing schools. This seems to be much more important than any of the alternatives or any of the results that seem to surface after this takes place. It would seem that the diploma nursing school would not be such a challenging competitor for the degree nursing schools if the benefits of the degree program were that much better. However, I get the impression that it is far more desirable from the ANA standpoint to stamp out these purveyors of infidelity and replace them with degree programs leading to BS Degrees, Masters Degrees, and/or Degrees as a Nurse Practitioner.

If there is any evidence to suggest that these programs

improve patient care, I would certainly enjoy the opportunity of observing it or reading it. It seems that really the most important thing in nursing education now is to learn how to correct the doctors and identify their mistakes. In dealing with sick patients rather than "routine" patients, the problem is certainly magnified. The degree nurses, even with years of experience, still seem to lack the expertise in dealing with sick patients that is exemplified by the diploma nurse within the first 12 or 18 months of training.

We read in the paper every day about the shortage of nurses and the various techniques being used to "remedy" this problem. Certainly the advocacy of the degree programs is not a solution to the nursing shortage. It is, however, more apparent that what the nursing degree program has in mind is relegating the care of the patient to the LPN and others in "elevating" the BSRN to a position of a professional who works side by side with the doctor rather than accepting the responsibility of following and carrying out the physician's orders. Somewhere along the way, these individuals are going to have to be allowed to write their own orders and it would seem to me it would be more appropriate, with this prevailing attitude, that the nurses procure their own patients through whatever means they desire. Personally, I resent having to share my patients with the degree nurses, because I feel like this duplicity is not cost effective in these years of the voluntary effort cost control.

As I go about my practice day by day, it is always quite apparent in observing the activities that go on in a hospital exactly what type training an individual has had. One particular nurse has assisted me in managing some GI bleeders in the past, and her ability, judgment, and expertise at managing a really critically ill patient is a joy to behold. You do not find this in working with nurses who are from purely degree programs. Occasionally, a diploma nurse who has gone back to school for her degree will get mixed in with this situation and then my argument seems inappropriate, but it is not the degree that makes this nurse so good, but the diploma school that she attended first which taught her how to really care for sick patients. Certainly the nursing education program with the ultimate product being the nurse practitioner is something not in keeping with the philosophy of MAG.

I feel that most medical schools are quite interested in accepting female applicants and, in fact, tend to go out of their way to encourage female applicants to medical school. It would seem to me that nurses who are particularly excited about practicing medicine should apply to medical school instead of trying to back into a situation using this approach. Unfortunately, doctors are accustomed to having nurses that they can count on as well as nurses that they can't count on and so, when they run into one who has her degree that doesn't seem to find time to look after the patient, the doctor will ignore this and hope that it passes and is as infrequent as possible. I think that if every doctor who reads this report were to tabulate the number of instances that occur to him individually, that we as a group would probably unite to reestablish some diploma nursing schools. It is not so important to me what type nursing schools they are referred to as what their product is. Certainly the product that is now being turned out is a step down from what we are accustomed to, but as we grow closer to National Health Insurance, I'm sure this will be less noticeable as other impeding factors increase.

SECRETARY

William D. Logan Jr., M.D.

This must have been a busy year as it has passed so quickly. Under the leadership of Dr. Atkins, we have carefully and deliberately managed our crises and look ahead to strengthen our purposes.

The amount of work that goes through the MAG office still amazes me, and I should like to take time in this report to recognize the tremendous effort done by our staff. Changing problems will always necessitate some shifting responsibilities, but I believe staff duty areas are better organized than I have seen before.

We have sorely missed Lola Brown, who has been away this year due to illness, but Miriam McLendon is quickly learning our various ways.

The decade of the "Eighties" began with many national and international anxieties, and many problems remain regarding the future of medicine. However, there seem to be a more sober and leveling attitude around this country, but I believe there will be more studied approaches and less turbulent, radical directions pursued in the near future.

This is partly due to the growing influence of organized medicine. We have been criticized a lot for entering the socio-economic and political arena over the past year, but I believe our solid support for the principles to which we adhere, is becoming much more recognized. Let us continue this fight.

It has been a pleasure for me to work with Mr. Moffett, Mr. Kidd, and the entire staff this year. I particularly appreciate the help and support of the Executive Committee and the Board of Directors. Together, we will continue to move forward.

Membership must be our highest priority. Without unity and members, we simply cannot get the job done. The following is a 5-year status report on MAG and AMA membership in Georgia:

	1979	*1978*	*1977*	*1976*	*1975*
Active	4,173	4,060	3,978	3,827	3,741
Active, I&R (Interns and Residents)	56	35	32	47	40
DE-1 (Financial Hardship/Illness)	68	64	60	61	65
DE-2 (Post-graduate Training)	8	11	10	15	15
DE-3 (Retired)	97	83	64	32	32
DE-4 (Temp. Duty, Armed Forces)	10	10	10	11	12
DE-5 (Life)	211	205	196	191	191
Associate	45	8	115	93	99
Service	56	64	66	66	62
Honorary	0	0	0	1	1
Affiliate	10	8	3	2	2
Student	1	1	3	2	2
DE-7	78	(65)	___	___	___
Totals	4,813	4,549 (4,614)	4,547	4,348	4,262
AMA Membership	3,776	3,524	3,456	3,347	3,259

Continuing Medical Education: This must be kept in the forefront. It is our best way to keep quality medicine available to our community. This year, MAG is recommending Dr. LaMar McGinnis to serve on the AMA Council on Continuing Physician Education. He is one of our finest and I hope he will be selected.

Information Systems: Since 1974, MAG has had a professional data processing staff. In 1978, the House

approved the expenditure of capital funds for the purchase of the Datapoint small business computer now installed in the MAG Headquarters building.

In November, 1979, MAG was awarded a contract for data services to the Georgia Medical Care Foundation's PSRO program as a result of competitive bidding. This contract has a maximum value of $148,402 per year and is renewable for a total of up to 3 years. At the end of that time, competitive bids will again be taken. In support of the PSRO project, an additional professional staff member has been hired, bringing the total to four. Additional clerical and paraprofessional staff will be added during the summer.

The major impact of PSRO on MAG's own operations is in the area of cost containment. By providing a broader basis for allocation of fixed costs, the portion which must be borne by MAG is reduced. The Information Systems Bureau uses a charge-back system for allocation of costs, and the cost of services to MAG has not been increased since the system was established in 1975. The cost of supplies has been increased only once, and for only one item.

In addition to PSRO, the computer is used to process payrolls for both MAG and the Foundation. The MAG Membership Information System, which includes membership records, dues accounting, and mailing list preparation, is on-line to the computer. It exchanges information directly with the AMA's computer via magnetic tape. Record-keeping for MAG's Physician Placement Service was automated in 1979.

Financial data processing and an on-line index of nearly 100,000 Medicaid patients are provided to the Foundation by Information Systems. An on-line Retrospective Hospital Claim Review system, designed and operated by MAG for the Foundation, has helped speed payment of Medicaid claims, cut costs for both the state and the Foundation, and allowed review efforts to be concentrated in areas where there appear to be problems.

The computer is also used by the Georgia Cancer Registry, which MAG operates under contract to the state, to maintain an index of tumor patients at more than 20 Georgia hospitals. This service, which is free to the hospitals, not only provides a valuable research tool to Georgia physicians but also helps the hospitals meet the accreditation requirements of the American College of Surgeons.

Information Systems has maintained its relationship with Emory University which allows MAG the use of a large and powerful scientific computer when necessary. However, to reduce our dependence upon outside resources, we have a systematic program of putting all new computer applications on MAG's own computer and of converting existing applications whenever possible.

From relatively modest beginnings in 1974, Information Systems has grown to have a well-qualified professional staff and modern equipment. By allocating a portion of our fixed costs to medically-related outside projects, MAG has been able to hold down the portion of the data processing budget paid from dues money and keep sensitive medical information under the control of organized medicine.

Georgia Cancer Registry Update: The Georgia Cancer Registry is currently operating under an 11-month contract with the Department of Human Resources. In July, 1979, the program was funded for $80,700.00, which was the same amount as the total funding for the previous year. Because of increased costs, it was felt that full services could be provided only for 11 months. Supplemental money in the amount of $8,500.00 will be made available to the Georgia Cancer Registry by the Department of Human Resources to provide services for the remainder of the fiscal year (June, 1980).

Twenty-eight Georgia hospitals currently participate in the program. To date, these hospitals have submitted information on 72,314 cancer cases in Georgia. This figure does not reflect the total cancer incidence for 1979. Routine statistical reports as well as special reports utilizing several parameters are made available to Georgia physicians and participating hospitals.

FIRST DISTRICT MEDICAL SOCIETY

Leon E. Curry, M.D., Director

The First District continues to be made up of loosely organized component medical societies which come together once annually for a very successful District Medical Society meeting usually held in Statesboro. Some societies are better represented than others, partly because of natural referral patterns and geographical factors.

The referral pattern of Laurens county physicians makes them more closely linked with Macon than with Savannah. As a result Dublin physicians are sparsely represented at our annual District Medical Society meeting. This year we were particularly pleased to have Roy Rowland, M.D., from Dublin address our assembly briefly. I believe he was the only representative from Dublin at our meeting.

This situation merits some attention in that Dublin physicians might attend better if they were in the District including Macon.

We have seen an influx of new physicians in our area, many of whom are foreign trained. They appear to be well accepted by patients and physicians alike and it appears their practices are up to acceptable standards as best we can determine by indirect methods.

Our District has made an all out effort to support GaMPAC this year. We hope this will enable us to continue to strive for appropriate legislative action effectively.

Fortunately our membership has grown more aware of the HSA presence in our area and its impact on the delivery of health care by independent practitioners. I am pleased to report that a majority of members present at First District Meeting were indeed members of HSA VII.

If the proposed change in the MAG Constitution passes, then we will need to give additional attention to the arrangement of Districts to correspond as much as possible with natural referral patterns, rather than blindly following Congressional Districts.

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Ogeechee River				
H. Randolph Smith				
Statesboro	35	26	34	29
Burke				
Walter R. Voyles				
Waynesboro	4	3	5	5

FIRST DISTRICT MEDICAL SOCIETY

Continued

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Emanuel				
Chang Kue Kim				
Swainsboro	6	4	6	5
Laurens				
Grady E. Longino				
Dublin	37	21	36	20
Screven				
Katrine R. Hawkins				
Sylvania	5	5	5	5
Southeast Georgia				
H. I. Conner				
Vidalia	12	5	14	6
St. John's Parish				
Wu H. Jeng				
Hinesville	10	0	9	1
TOTAL	109	64	109	71

SECOND DISTRICT MEDICAL SOCIETY

J. Dan Bateman, M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Colquitt				
William O. Brown				
Moultrie	17	14	23	15
Decatur-Seminole				
Napoleon G. Matucan				
Bainbridge	12	9	12	9
Dougherty				
Frank F. Middleton III				
Albany	90	69	101	83
Mitchell				
A. A. McNeill Jr.				
Camilla	6	4	7	5
Southwest Georgia				
Virendra M. Saxena				
Ft. Gaines	10	1	10	3
Thomas Area				
William A. Lardin				
Thomasville	51	35	52	38
Tift				
James Scott				
Tifton	25	17	31	21
Worth				
H. O. Eason				
Sylvester	4	1	3	2
TOTAL	215	150	239	176

These times of ours are serious and full of calamity, but all times are essentially alike.

Ralph W. Emerson, 1864

THIRD DISTRICT MEDICAL SOCIETY

V. W. McEver, Jr., M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Flint				
Charles Greer				
Cordele	18	11	17	13
Peach Belt				
James Q. Whitaker				
Warner Robins	43	34	42	36
Randolph-Stewart-Terrell				
Thomas M. Allen				
Dawson	5	5	5	4
Sumter				
William R. Anderson				
Americus	19	11	22	17
TOTAL	85	61	86	70

DEKALB MEDICAL SOCIETY

John P. Heard, M.D., Director

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
DeKalb				
William R. Hardcastle				
Tucker	288	199	322	221

MEDICAL ASSOCIATION OF ATLANTA

John T. Godwin, M.D., Director

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Medical Association of Atlanta				
W. Ben Spearman				
Atlanta	1204	804	1229	937

SIXTH DISTRICT MEDICAL SOCIETY

James M. Skinner, M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Clayton-Fayette				
Raymundo Mallari				
Riverdale	62	26	68	41
Coweta				
Frederick E. Gilbert				
Newnan	23	19	22	20
Meriwether-Harris-Talbot				
William G. Chambless				
Hamilton	8	7	9	5
Spalding				
James M. Skinner				
Griffin	36	30	36	31
Troup				
John T. West				
LaGrange	50	37	52	42

SIXTH DISTRICT MEDICAL SOCIETY

Continued

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Upson Ralph P. Warnock Thomaston	26	14	26	18
TOTAL	205	133	213	157

SEVENTH DISTRICT MEDICAL SOCIETY

Richard A. Griffin III, M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Bartow William B. Dillard Cartersville	8	6	8	6
Carroll-Haralson* William S. Harris Carrollton	43	31	37	26
Douglas* A. Clark Robinson Douglasville			16	9
Gordon Joseph A. Bishop Calhoun	7	5	6	4
Walker-Catoosa-Dade Ralph Greene Ringgold	37	24	36	29
Whitfield-Murray F. Barry Hodges III Dalton	58	46	64	53
TOTAL	153	112	167	127

* Douglas County split from Carroll-Haralson 1/1/79 to form the Douglas County Medical Society.

EIGHTH DISTRICT MEDICAL SOCIETY

Joe C. Stubbs, M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Altamaha L.Q. Poblete Baxley	3	2	6	3
Ben Hill-Irwin Ralph Roberts Fitzgerald	5	4	6	5
Coffee Jack G. Williams Douglas	17	12	16	13
Camden-Charlton Ramon V. Alvarez St. Marys	6	3	7	4
Glynn James F. Gowen Brunswick	67	42	66	52
Ocmulgee W. E. Coleman Hawkinsville	17	12	16	14
South Georgia A. T. McRae Valdosta	71	37	70	44
Telfair D. B. McRae McRae	4	3	4	3
Ware Howard A. Griffin Waycross	50	31	58	38
Wayne O. O. McGahee, Jr. Jesup	9	8	9	8
TOTAL	249	154	258	184

NINTH DISTRICT MEDICAL SOCIETY

Rupert H. Bramblett, M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Barrow Hugh O. Hodges Winder	7	3	7	4
Blue Ridge Robert A. Burns Blue Ridge	3	2	5	5
Chattahoochee Rupert H. Bramblett Cumming	31	24	33	24
Cherokee-Pickens Robert T. Anderson Canton	16	9	16	11
Elbert M. H. Arnold Elberton	9	5	10	5
Franklin-Hart Robert F. Sullivan Carnesville	8	8	9	9
Habersham Fletcher O. Garrison Cornelia	11	7	9	6
Hall James H. Leigh Gainesville	97	76	112	79
Jackson-Banks Sam A. Vickery Commerce	6	4	6	6
Stephens-Rabun John Payton Toccoa	25	11	24	8
TOTAL	213	149	231	157

TENTH DISTRICT MEDICAL SOCIETY

M. A. Hubert, M.D., Director

Counties and Secretaries	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Baldwin P. L. Tamayo Milledgeville	48	19	49	24
Crawford W. Long Larkus H. Pesnell Athens	76	55	81	61
Jefferson J. B. Polhill Louisville	6	3	4	3
McDuffie M. N. Whaley Thomson	4	4	5	5
Newton-Rockdale G. G. Tuck Covington	19	8	22	12
Oconee Valley Rose A. R. Weaver Madison	9	7	10	8
Walton James H. Barton Social Circle	10	8	11	9
Washington William Rawlings Sandersville	7	2	7	1
Wilkes Gene Pollock Washington	5	5	4	4
TOTAL	184	111	193	127

BIBB COUNTY MEDICAL SOCIETY

Beverly B. Sanders, M.D., Director

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Bibb C. Emory Johnson Macon	215	161	221	169

COBB COUNTY MEDICAL SOCIETY

Charles R. Underwood, M.D., Director

The Cobb County Medical Society enters the era of the 80's with a comfortable record of steady growth over the past decade and with hopeful plans to continue that growth into the next one. Spencer Mullins has assumed our presidency from Frank McKinnon, and we look forward to great leadership from him. Our efforts at amassing all of the physicians in the county as members of the MAG continue, and we are now happy to find a high percentage of the county physicians as members of the MAG. Our long-time activities, such as the Cobb County Symposium, the annual Medical-Legal Banquet, county high school athletic physicals, and the annual dinner and strategy session with the county legislators, continue alive and vibrantly healthy. The officers of the County Society are looking at several new avenues by which the vitality of the Society can be maintained and greater service to the community provided. Our county hospitals, of which there are now six, continue to prosper and in general maintain a most favorable and cooperative attitude toward the physician population. Our County Society sees the challenge of the 80s as a move from entrenched physician dominance and self-protection to a cooperative attitude with the public, making efforts not only to involve the general public more usefully in providing health care and a healthy environment but also to show some practical results of this cooperative effort.

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Cobb Charles J. Rey Jr. Austell	258	155	265	170

FLOYD-POLK-CHATTOOGA MEDICAL SOCIETY

John I. Dickinson, M.D., Director

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Floyd-Polk-Chattooga Toby S. Morgan Rome	101	71	106	76

GEORGIA MEDICAL SOCIETY

Joe L. Nettles, M.D., Director

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Georgia Medical Society Eloise B. Sherman Savannah	226	184	234	208

MUSCOGEE COUNTY MEDICAL SOCIETY

Jack A. Raines, M.D., Director

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Muscogee Kenneth L. Goldman Columbus	211	156	232	177

RICHMOND COUNTY MEDICAL SOCIETY

Ronald F. Galloway, M.D., Director

The Richmond County Medical Society continues to represent physicians in the community. We have grown in numbers. Under the present leadership of Dr. James O'Quinn, our President, we anticipate another active and productive year. We have no specific recommendations to make to the House of Delegates at this time.

County and Secretary	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying	Members 12/31/79 MAG	Members 12/31/79 AMA Dues Paying
Richmond				
Donald Abele				
Augusta	344	270	350	281

COMMITTEE ON AUXILIARY

M. A. Glucksman, M.D., Chairman

The Committee on the Auxiliary has not held a meeting this year. However, on request of the President of the Auxiliary, the members of the Committee were polled by mail on the advisability of increasing the interest rate charged after medical school graduation by the Auxiliary's Dancy Student Loan Fund. The members of the Committee approved the proposed rate increase.

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS COMMITTEE

Charles E. Harrison, M.D., Chairman

The committee on the Composite State Board of Medical Examiners did not have a formal meeting in this year. However, the committee was in communication by telephone and letter regarding several topics during the year in lieu of an organized meeting.

The deliberation of our informal committee meetings resulted in the committee presenting to the MAG Board of Directors recommendations for progress in formalizing and presenting the MAG's viewpoints on the alteration of the Composite State Board of Medical Examiners (CSBME). The main topic of our discussions has been the strategy and proposals to implement the MAG position, adopted a year ago, to divide the CSBME into a two-tiered board.

Through the efforts of this committee and MAG, a meeting with Governor George Busbee was held in December, 1979, to discuss the appointment process for the members of the Board of Medical Examiners. This meeting came about after settlement of the John Rogers lawsuit, which overturned existing law which stated that the Governor was required to appoint members of the CSBME from a list of names submitted to him by the MAG.

It is the understanding of this committee and MAG that Governor Busbee plans to replace the vast majority of existing M.D. members of the Board of Medical Examiners, as their terms have already expired. It seems appropriate to this committee that this would be an ideal time for implementation of the two-tiered Board of Medical Examiners.

As chairman of this committee, I have scheduled a meeting with Governor Busbee for Tuesday, March 25, for the sole purpose of discussing our two-tiered proposals. The result of this meeting will be presented to the MAG Board of Directors, and if necessary, as a supplemental report to the report of the CSBME.



Ron Galloway, M.D., from Augusta, was Parliamentarian again this year.

I would like at this time to thank the members of this committee for their diligent efforts in behalf of working with the CSBME and working for the MAG devising what we feel is a workable system for the Board of Medical Examiners.

The members are: Benjamin S. Anderson Jr., M.D., Cedartown; S. W. Clark Jr., M.D., Waycross; Albert M. Deal, M.D., Statesboro; John H. Deaton, M.D., Columbus; Phillip Israel, M.D., Marietta; Julius T. Johnson, M.D., Augusta; William E. Mayher III, M.D., Albany; LaMar S. McGinnis Jr., M.D., Decatur; Julian K. Quattlebaum Jr., M.D., Savannah; A. Cullen Richardson, M.D., Atlanta; Wells Riley, M.D., Jonesboro.

COST AWARENESS COMMITTEE

H. Duane Blair, M.D., Chairman

During the past year we have seen emphasis from the local and national levels swing from that of intense public and private efforts to, with the emasculation of the National Cost Containment Bill, one of a great deal of apathy. It is the committee's belief that government efforts will not cease and that there will be continued efforts in one way or another to impact on the private physician and hospitals in this area. The committee intends to help intensify local efforts as much as possible for the next year.

The Cost Awareness Committee reviewed MAG's policy on cost awareness and the November 1978 Report of the Cost Accountability Committee of the Medical Association of Atlanta (MAA). As recommended by the committee, the MAG Executive Committee approved continuing MAG's current principles on cost awareness and recommended the use of the MAA report as resource material for the county societies or other interested local agencies, such as hospital cost awareness activities.

The committee sponsored a statewide conference on Positive Approaches to Cost Awareness at the Peachtree Plaza Hotel, Atlanta, August 25, 1979. Approximately 75 individuals including physicians, hospital administrators, health planning personnel, business, consumer representatives, public officials, etc. attended. The concept of the conference was to get as many different ideas as



Public Relations Committee Chairman, Charles W. McDowell, Jr. (L), reports to the House, while James Kaufmann, Chairman of MAG's Legislative Committee, waits his turn.

possible across to local people for utilization within their own areas. Panelists represented AMA, AHA, BC/BS, hospital administrators, the U.S. Senate Finance Committee, and Interstudy (health economists — HMO concept). One unique aspect included input from representatives of the Medical College of Georgia and Morehouse School of Medicine regarding efforts within medical schools to make medical students aware of this important part of medical care.

The committee has identified and, in some instances, modified four educational cost awareness brochures: Two patient educational brochures, "To Your Good Health/ Why Medical Care Costs Have Increased," and "Your Health Is in Your Hands;" and two physician pamphlets, "Physician Cost Containment Checklist," and "Physician Fee and Cost Indicators" as developed by the AMA. The concept of development and distribution of these brochures has been approved by the Executive Committee.

In addition to continuing to work with the Education Committee and the Public Relations Committee in the further development of patient and physician informational brochures, the committee is continuing to work with the Voluntary Effort (VE). The chairman and staff attended the 1979 VE Symposium sponsored by the National VE. In addition to reviewing state activities, emphasis was placed on 1980 goals in which greater input from physicians will be requested. For your information, the VE Goals and Objectives for 1980 and Beyond, as approved by the National Steering Committee for the VE December 1979, are listed below:

VE Goal for 1980 and Beyond

To continue to restrain the increase in health care costs so that a closer and more consistent relationship between total health care expenditures growth and growth in the total Gross National Product is achieved.

VE Priorities

1. *The Scope of the VE*
 Programs and activities of the VE at national, state, and local levels will be geared to cost containment and cost effectiveness in all sectors of the health care field.
2. *Long-Term Cost Effectiveness for 1980 and Beyond*
 The National Steering Committee, as a coalition and through each of its partner organizations, will address methods of improving the overall cost effectiveness of the health care system on a continuing basis, without detriment to either the quality of or access to that health care.
3. *Improving Productivity*
 All sectors of the health care field should strive to make substantial improvements in productivity.

VE 1980 Objectives

1. *Hospital Expenditures for 1980*
 Hospitals should keep their operating and capital expenditures at the lowest possible level, consistent with quality of care. This objective should be achieved through a continued effort by hospitals to improve their efficiency and effectiveness, especially in regard to measurement and improvement of labor productivity; tightened utilization review and quality assurance mechanisms; energy conservation; group purchasing and other shared services; overall corporate planning, budgeting and control processes; and identification and resolution of any unnecessary facilities and services capacity.

 Numerical Target: The national increase in total inpatient community hospital expenditures in 1980 should decelerate by 1.5 percentage points from 1979. Achievement of this objective is contingent on no increase in the general, economy-wide inflation rate in 1980 over the 1979 level.
2. *Hospital Beds*
 In 1980, the total number of hospital beds should be held at the level as of December 31, 1978, adjusted for any new beds that might be added due to certificate-of-need approvals prior to that date.
3. *Hospital Productivity*
 Growth of full-time equivalent (FTE) employment in hospitals in 1980 should be held to the lowest level possible. Each hospital should develop or continue internal management engineering and performance standard programs designed to improve productivity. These programs should include flexible staffing patterns tied to volume of service measures. There also should be an expanded effort by state VE committees to develop programs to measure and significantly improve productivity, staffing patterns, and restraint in FTE levels.

 Numerical Target: The growth of FTEs per 100 daily census in hospitals should continue to decline in 1980 from the 1979 level.
4. *Medical Staff Utilization*
 All hospital medical staffs should reaffirm their commitment to carry out effective, ongoing voluntary utilization review programs covering all physician services within the institution. All hospital medical staffs should consider ways to further tighten utilization review programs, consistent with sound medical practice. Steps should be taken in areas of the country that are significantly different from national averages (e.g., measures such as length of stay, admissions per 1,000 population, etc.), to assess these differences and reduce them to appropriate levels. Physicians should continue to reassess existing medical practice patterns as part of this process and should continue their efforts to become better informed as to the cost of the tests and services they order. In all of these efforts, physicians should work closely with hospital management.

All undergraduate, postgraduate, and continuing medical education programs should include courses in cost containment and cost effectiveness in their curricula.

5. *Physicians' Fees*
 The AMA advocates that physicians, during the first half of 1980, continue to voluntarily restrain their fee increases to a level that maintains the 1979 relationship between the All-Items Index and the Physicians Service Index of the CPI. This target will be reassessed in mid-1980. The NSC endorses AMA's policy and its programs to assist physicians in this regard.
6. *Manufacturers and Suppliers*
 Each health care product manufacturer and supplier should support voluntary cost containment programs and independently exercise restraint in its pricing policies. Purchasers of health care supplies and products should independently resist extraordinary high price increases.
7. *Payment Systems, Incentives, and Consumer Demand*
 Insurance carriers, other purchasers of care (public and private), business, and organized labor should examine cost-effective alternatives to existing health insurance programs, including consumer cost sharing and other approaches to heighten the awareness of the health care consumer regarding the cost of health care. New insurance benefits or substantial expansion of existing coverage should be carefully assessed on the basis of their cost effectiveness and inflationary impact, based on the national goals, objectives, and broad directions of the VE in 1980. Cost containment programs should be tested and instituted, for example: various incentive payment programs; utilization review programs; and support of improved area-wide planning. Insurance carriers and government should examine ways to further decelerate their administrative cost increases in carrying out their activities.
8. *Health Care Regulations and Legislation*
 Health care legislation, regulations, and administration procedures have in many instances contributed adversely to rising health care costs. The Department of Health, Education, and Welfare and other national and state agencies should decelerate their administrative cost increases in carrying out their activities. Cost-effectiveness studies regarding all existing regulations and standards that have a substantial impact on the health care field should be carried out. An in-depth analysis of the cost effectiveness and inflationary impact of proposed health care legislation and regulations also should be made before any new action is taken.
9. *Health Promotion and Illness Prevention*
 The individual VE partners should develop, implement, and evaluate programs at the community level aimed at promoting increased responsibility on the part of the individual consumer for his or her own health, and for helping to reduce or eliminate the individual consumer's potential health risks.
10. *Public Education*
 A program of public education should be undertaken at all levels to explain to the public the progress that the health care field is making in restraining cost increases through voluntary action. The public education program should include ways to actively include consumers, business, labor, and others in voluntary cost containment efforts, and to improve public understanding of the reasons why health care costs are increasing.

AD HOC COMMITTEE ON DRUGS

Stanley P. Aldridge, M.D., Chairman

This is a new committee which is charged with "the responsibility to interface with those individuals and groups outside the MAG and to make recommendations to the Executive Committee and Board of Directors as to the proper position or course of action to be taken by the MAG.

The chairman of this committee met with representatives of the Georgia Pharmaceutical Association to discuss problems relating to those drugs which the FDA has released from prescription requirement to over-the-counter drugs. The possibility of establishing a third class of drugs has been discussed. This will be addressed in the upcoming year, with the possibility of the Georgia Pharmaceutical Association introducing legislation at the next General Assembly.

The committee will also be addressing other concerns as they arise in the year.

LEGISLATIVE COMMITTEE

James A. Kaufmann, M.D., Chairman

The MAG Legislative Committee officially met twice this year to discuss areas of legislative concern to MAG and approaches to get our message across to our elected officials. Our committee, without question, agreed that the best way to achieve favorable legislative results is for the individual physician, THIS MEANS YOU, to take an active part in the legislative process.

The legislative process means:

1) Know your state senator
2) Know your state representative
3) Know your U.S. senator
4) Know your U.S. congressman
5) Know your mayor
6) Know your city councilmen
7) Know your county commissioners

CAN YOU EVEN NAME THESE PERSONS? IF SO, DO YOU KNOW THEM? DO THEY KNOW YOU?

The commentary is probably very, very sad, in that most are so apathetic to the process that increases daily to control our lives, the health care and well being of our patients, and our medical practice that we do not know or have taken the time to find out the above.

DID YOU VOTE? DID YOU SUPPORT A CANDIDATE?

Records indicate most physicians do not vote. How can you expect to have a voice in the legislative process if you don't even vote!

Pick a candidate — any candidate — support them with a financial contribution. Support them by offering any assistance needed. Work for their election — don't just give lip service and worst yet, don't be the one who complains about the process when you did not care enough and take the minute amount of time and effort to become involved.

The preservation of the practice of medicine is your involvement — not what you have or have not done in the past, but WHAT YOU DO IN THE FUTURE and the FUTURE IS *NOW*!

The 1980 Georgia General Assembly saw twice the amount of health-related legislation than in years past. With only 40 legislative days, your legislators were asked to vote on some 163 health matters. The MAG Legislative Committee gave formal testimony before 16 different state legislative committees on 46 issues. Informal testimony was given on another 67 health bills, and we followed closely all amendments, etc. on the remaining 53 to insure they were not adversely changed.

The following is a list of just a few of those 163 pieces of legislation that went before the Georgia General Assembly in the 40-day, 1980 legislative session:

Inpatient – Outpatient Insurance

Senate Bill 217, which passed, sets up a mechanism by which the insurance commissioner's office, in concert with the Department of Human Resources and the Georgia Medical Care Foundation, will promulgate rules and regulations to insurance companies of Georgia requiring that certain procedures that are currently reimburseable only on an inpatient basis will be reimbursed on an outpatient basis for individual insurance policies.

Optometry

Senate Bill 44 and House Bill 394, which permitted optometrists the use of diagnostic agents, did not pass; however, SB 31, which dealt only with adding a consumer to the Board of Optometry, was amended by substitute on the floor of the House by Representative Phil Johnson of Covington and Representative Crawford Ware of Hogansville to include in essence the substance matter of Senate Bill 44 permitting optometrists to use diagnostic agents. The MAG and the Georgia Society of Opthalmology the past five years were successful in defeating said legislation in respective committees, however, were unable to defeat this subversive tactic during the 1980 session. SB 31 as amended passed the Senate by only three votes.

Medicaid Appropriations

Among the highly controversial appropriations bill, the MAG was successful in assisting in the addition of some $4,000,000 plus into the benefits payment division of the Department of Medical Assistance (DMA) for reimbursement of physician's medicaid fees. In accord with this additional money, language was established into the DMA to equate physician's fees throughout Georgia. In essence, this would bring Georgia into a one area designation of medicaid reimbursement.

Canadian Medical Licenses

House Bill 599 was the first bill to become law this year and permits graduates of approved Canadian medical schools to apply for and receive a license to practice medicine in Georgia.

Definition of Physician

House Bill 652 was withdrawn late in the session when the Attorney General and the Insurance Commissioner indicated that current laws and regulations specify only medical doctors and osteopaths can consider themselves physicians.

Emergency Medical and Cardiac Technicians – Ambulance Service

House Bill 1376, which passed, permits the Composite State Board of Medical Examiners to subpoena records of ambulance services regarding the use of emergency medical and cardiac technicians. HB 1376 also requires that all ambulance services in counties of above 12,000 population have a medical advisor to each and every ambulance service.

Medicaid Filing of Claims

House Bill 1099, which passed, extends to 6 months the time of filing a claim for medicaid by physicians and hospitals. This addition of time should greatly benefit the hospital and physician claims filing process.

Fifth Pathway Program

House Bill 885, which would mandate Georgia have a Fifth Pathway Program, did not pass. MAG, the State Board of Medical Examiners, and the Medical College of Georgia have been in opposition to a mandatory Fifth Pathway Program.

Podiatry

House Bill 1403, which would require hospitals to consider applications for staff privileges from podiatrists and others, did not pass. House Bill 1404, which changed the limitations of advertisement for podiatrists did not pass. House Bill 1405, which changed the definition of podiatric practice to treating ailments of the human foot and leg distal to the knee, did not pass.

Chiropractic

House Bill 228, which passed, permits chiropractors to be reimbursed for services within their scope of practice under health and accident insurance policies. The language of HB 228 permits insurance companies to specifically exclude chiropractic services if they so desire to do so.

Experimental Research – Marijuana

House Bill 1077, which passed, permits Georgia physicians and patients who qualify under the Composite State Board of Medical Examiners in accord with rules by the FDA, to use marijuana in the experimental research for cancer patients and glaucoma patients.

Eye Banks

House Bill 1186, which passed, permits the removal of eye tissue from decedents for the purpose of cornea transplants, etc.

Medical Examiner – DeKalb County

House Bill 1234, which passed, permits DeKalb County to abolish the office of Coroner and replace said office with a full-time medical examiner.

Mental Disorder Insurance

House Bill 83, which did not pass, would have required insurance companies to offer at parity mental illness benefits. These benefits would be strictly up to the purchaser to buy and pay accordingly. HB 83 would not have mandated the inclusion of said coverages.

Sterilization Procedures

House Bill 122, which did not pass, would have changed existing law to require two physicians to consult prior to a sterilization procedure and a waiting time of 90 days.

Catastrophic Health Insurance

House Bill 139, which passed the House of Representatives but did not pass the Senate, would have established a mechanism by which insurance companies would offer and include catastrophic benefits in health and accident insurance policies.

Confidential Psychiatrist-Patient Privilege

Senate Bill 115, which would have breached the confidentiality between psychiatrist and patient, was defeated.

Joint Emergency Medical Services Study Committee

House Resolution 514, which passed, creates a Joint Emergency Medical Services Committee. The purposes of this committee are to study the problems of emergency medical services, to study the delivery of emergency medical services and to report to the General Assembly in 1981 their findings regarding emergency medical services in Georgia. The committee shall be composed of four members of the State Senate, four members of the House of Representatives, six citizens of the state, two of which shall be representatives of private ambulance providers and two which shall be representatives of public ambulance providers. The MAG will attempt to have M.D.s appointed as citizen members to this study committee.

Medical/Dental License Revocation

House Bill 40, which passed, requires that in contested cases involving a license to practice medicine or dentistry where the medical board or dental board has revoked the license, the reviewing court may order a stay or an agency may grant a stay only if such court or agency makes a finding that the public health, safety, and welfare will not be harmed by the issuance of the stay.

Good Samaritan Act

House Bill 63, which did not pass, would add to the Good Samaritan Act nurses, firemen, civil defense workers, Red Cross workers, law enforcement personnel and those persons certified in cardio-pulmonary resuscitation who render emergency care at the scene of an accident or emergency, would not be liable for any civil damages. Currently, only those persons licensed under 84-9, medical doctors and osteopaths, have this civil immunity for rendering medical care.

Professional Counselors Licensing Act

House Bill 103, which did not pass, would create a new board of licensed professional counselors. It would have provided for their duties, compensation, appointment, terms, officers, meetings, defnitions, and would have repealed the "Marriage and Family Counselor Act" which passed in 1976.

Professional Health Care Review Organization – Immunity From Liability

House Bill 553, which passed, provides immunity from liability for persons providing information to a professional health care organization.

Georgia Bureau of Investigation – State Crime Laboratory

House Bill 688, which passed, creates within the Georgia Bureau of Investigation the State Crime Laboratory name change to the "Division of Forensic Sciences" within the Georgia Bureau of Investigation.

Georgia Controlled Substances Act

House Bill 845, which passed, defines a drug-related object as any instrument, device, or object which is primarily intended for the following purposes: inject, ingest, inhale, or otherwise induce into the human body marijuana or a controlled substance. It shall be unlawful for any person to sell, offer to sell, exchange, or offer to exchange any drug-related object to any person. The violation of said act is punished as a misdemeanor.

Hospital Service Non-Profit Corporations

House Bill 1101, which passed, states that not more than 50% of the directors of a hospital service non-profit corporation may be directors, superintendents, trustees, or employees of hospitals.

Georgia Controlled Substances Act – Mandatory Minimum Terms of Imprisonment

House Bill 1155, which passed, states any person who violates Section 79A-881 (A) with respect to a controlled substance in Schedule One or narcotic drugs in Schedule Two shall be guilty of a felony and shall be punished by imprisonment for not less than 2 years nor more than 15 years. Upon imprisonment of a second or subsequent offence, he shall be imprisoned for not less than 5 years nor more than 30 years. Any person who violates Section 79A-811 (B) with respect to controlled substances in Schedule One or narcotic drugs in Schedule Two shall be guilty of a felony and be punished by imprisonment for not less than 5 years nor more than 30 years. Upon conviction of a second offense, he shall be imprisoned for life. Any person who knowingly sells, manufactures, delivers, or brings into this state, or who is in actual possession of 28 grams or more of cocaine or of any mixture containing cocaine shall be sentenced to a mandatory minimum term of imprisonment of 5 years and a fine of $50,000; possession of 200 grams or more shall be a sentence to a mandatory term of 7 years and a fine of $100,000; 400 grams or more shall be a sentence of a mandatory term of imprisonment of 15 years and a fine of $250,000.

Regulation of Ambulance Services

House Bill 1188, which did not pass, stated that any law enforcement agency of any county or municipality which requests ambulance services for any person in the custody of said agency shall be deemed to have made a valid and binding contract for any such requested services rendered if such services were not provided by an ambulance service of a government or governmental agency. If collection of said ambulance service fees are unable to be

obtained, said county or municipality shall reimburse the ambulance service for said fees.

Georgia Emergency Telephone Number – 911

House Bill 1189, which passed, amends the 911 Service Act of 1977 to not only require an effective 911 telephone system throughout the state but also to require the marking of all vehicles used for the enforcement of traffic laws and public safety in this state to have adequately printed on said vehicles the numbers 911 for emergency telephone service.

Pharmacy – Regulations, Board of Pharmacy

House Bill 1225, which passed, requires a mandatory retirement of persons serving on the State Board of Pharmacy, establishes a compensation for the Board of Pharmacy, establishes a mechanism for voluntary continuing medical education of a Georgia licensed pharmacist, and adds certain drugs to the Georgia Dangerous Drug list.

Several amendments and substitutes were added to and taken off HB 1225 during the course of this session. One such substitute and amendment dealt with who could and could not communicate an oral prescription to a pharmacist. The Georgia Board of Pharmacy, the Georgia Pharmaceutical Association, and the MAG proposed an amendment to clarify existing law stating when, and only when, an agent of a licensed practitioner could communicate an oral prescription to a pharmacist. This amendment stated that only upon the order of a licensed practitioner, as defined by the Board of Pharmacy, meaning medical doctors, osteopaths, dentists, and veterinarians, could their agent communicate an oral prescription to a pharmacist. This amendment was withdrawn late in the session so as not to jeopardize the original HB 1225.

Ambulance Services

House Bill 1250, which passed, provides that any emergency medical technician, advanced emergency medical technician, or cardiac technician who is certified under the provisions of Georgia Code Chapter 88-31 and works for a county or municipal police department, fire department, or rescue unit is authorized to obtain any substance which said emergency medical technician, etc. is authorized to administer by virtue of his certification. Any such unit to which the emergency medical technician, advanced emergency medical technician, or cardiac technician is attached must be licensed with the Department of Human Resources as a medical first responder unit. Such unit may only obtain from the hospital pharmacy those legend drugs listed and legally permitted to be used by advanced emergency medical technicians, emergency medical technicians, or cardiac technicians.

Home Health Care Agencies

House Bill 1391, which passed, establishes a mechanism for the licensure of Home Health Care Agencies and authorizes, under the direction of the Department of Human Resources, to develop rules, standards, and regulations governing the regulation of licensing of Home Health Agencies. A "Home Health Agency" shall mean a public non-profit proprietary organization, whether owned or operated by one or more persons or legal entities, which is engaged in furnishing home health services. "Home Health Services" shall mean those items and services furnished to an individual, according to a written plan of treatment signed by the patient's physician, by a Home Health Agency or other arrangement of the Home Health Agency, on a visit or hourly basis, in a place of temporary or permanent residence used as the individual's home.

Alcoholism and Intoxication Treatment Act

House Bill 1508, which passed, extends once again the effective date to July 1, 1981, the implementation of the Georgia Comprehensive Treatment of Alcoholism and Intoxication Act.

Joint Advisory Board of Family Practice

House Bill 1510, which passed, amends the Joint Advisory Board of Family Practice to state not only shall the Board meet the American Medical Association's essentials for residency training and family practice, but also shall meet guidelines, rules, and regulations of the American Osteopathic Association for post-graduate study in general practice and shall be approved by the American College of General Practitioners and Osteopathic Medicine and Surgery.

Cost of Pharmaceuticals – Elderly Georgians

House Bill 1578, which passed, sets up a new act known as the "Pharmaceutical Cost Relief Act for Elderly Georgians." The purpose of this act is to provide direct assistance to those among Georgia's elderly in need of assistance and relief for the payment of a portion of the cost of prescription drugs. Administration of said act shall be in accordance with the "Georgia Medical Assistance Act of 1977 — Medicaid."

Spinal-Cord Disabled Persons

Senate Bill 11, which passed, asks every public and private health and social agency and every physician in this state to report to the Department of Human Resources any person who is spinal-cord disabled. Spinal-cord disabled means any spinal cord disease, injury, or neural tube defect, whether congenital or acquired, which results in partial or total loss of motor or sensory functions and which results in partial or total disability, whether such disability is temporary or permanent.

Alcoholic Beverage – Drinking Age

Senate Bill 68, which passed, lowers the legal drinking age from 21 to 19 and permits those persons serving in the armed services who are less than 19 years of age to present their military service card in order to obtain alcoholic beverages.

Right to Die – Living Will

Senate Bill 86, which did not pass, would have established in Georgia law, a legal mechanism by which persons could authorize physicians to discontinue life support systems. Currently there is no law in Georgia establishing a legal mechanism by which a physician could discontinue life support systems.

Psychologist's Insurance

Senate Bill 169, which passed, states all individual and group insurance policies of accident and sickness insurance which provide coverage for services which are within the lawful scope of practice of an applied psychologist,

duly licensed in this state, shall be deemed to provide that any person covered under such policies or contracts shall be entitled to receive reimbursement for such services under such policies.

State Medical Education Board

Senate Bill 498, which passed, would establish under Georgia law, not Georgia Constitution, the State Medical Education Board. The make-up of this Board would be five members, one of whom shall be the president of the MAG, and one of whom shall be the immediate past-president of the MAG, and three members to be appointed by the governor, who are qualified electors of the state. The purpose of said Board is to provide for loans and scholarships and for requirements in connection with contracts and certain arrangements for persons to attend certain medical colleges.

From the above mentioned House and Senate bills you can readily see the complexity of the issues, the number of the issues, and the increasing degree of involvement of our legislators in the practice of medicine and the health care of Georgians.

Although this was the most frustrating year one can remember at the Capitol, the successes of the MAG legislative programs greatly outweighed the few failures.

One is forced to wonder if there would have been even one failure if there had been 20-30-50 M.D.s roaming the halls of the Capitol at one time, as do members of other groups who DO TAKE AN ACTIVE PART in the legislative process.

WHERE WERE YOU? ARE YOU WILLING? IF SO — SEE YOU this fall during election year and next January, February, and March at the State Capitol.

MATERNAL AND INFANT HEALTH COMMITTEE

Luella M. Klein, M.D., Chairman

The past year has been an interesting one for the Maternal and Infant Health Committee. We heard reports from representatives of the Program Evaluation Branch of the Family Planning Evaluation Division of the Center for Disease Control (CDC) relating to unrecognized maternal mortality in Georgia from 1974 through 1976, underreporting of neonatal deaths in Georgia from 1974 to 1977, and risk factors associated with neonatal mortality in Georgia from 1974 to 1976. As a result of the studies undertaken by CDC, it was estimated that there was a 21% underreporting of neonatal deaths in Georgia during 1974 to 1976, and 11 maternal deaths were identified which had not previously been reported in 1975 and 1976.

Michael Lavoie, Director of the Vital Records Service of the Department of Human Resources (DHR), requested the Committee's assistance in review of some proposed changes in the birth certificate for Georgia. The committee did recommend to the Executive Committee that MAG oppose the inclusion of the social security number. In response to the Executive Committee request, the DHR advised the MAG that this item is included in information which is not used at the national level. Although it appears from the form to be required, physicians are instructed to omit it if the patient objects to its inclusion.

The Committee also reviewed extensively the proposed Level II and Level III Perinatal Unit Standards developed by the State of Georgia Council on Maternal and Infant Health. Comments from this meeting were submitted to the Council which is using them in their revision process of these Standards.

The problem, particularly in small hospitals, relating to supply of blood was discussed with a representative from the American Red Cross. Dr. Jane Jennings, a practicing pathologist from Savannah, who serves as the Medical Director of the Blood Services in the South Atlantic Region for the American Red Cross, reported that the Red Cross became aware of the problem of trying to meet the minimum standard requirements as it worked with the Laboratory Licensure Division of the Department of Human Resources in 1977-78. Blood supply is particularly a problem with the small (50 to 150 bed) hospitals.

In an effort to solve some of these problems, the South Georgia Division of the Red Cross developed a subcenter system. A subcenter is established to meet the needs within a radius of 30 to 50 miles of the center. The North Georgia, or the Atlanta Region, does not utilize this particular system. The Red Cross is in complete agreement with what the Committee is trying to do. However, the problem is supply. The percent of type "O" blood available is too small and in some instances outdated supply also is a problem. During the discussion of this problem, several suggestions were made for the enhancement of recruitment for blood. The majority of committee members appeared to feel that some system to collect blood from the family of those who receive the blood would be more effective than the centralized system now in existence. There was some discussion as to the possibility of developing a mechanism for collection at the hospitals with processing by the Red Cross. Dr. Jennings reported that this had been tried in one area, but was not as effective as had been desired. Questions also arose as to how many hospitals offer OB services, how many have been inspected, how many are in compliance with the blood requirements, is this compliance an actual compliance or by a plan for supply, and which ones are not in blood and/or blood product compliance. It was agreed that the committee chairman would write to Mr. Scott Sprinkle, Director of the Office of Regulatory Services, Georgia DHR, for an updated answer to these questions. Staff will also review the maternal deaths for last 3 years to determine how many of these were directly related to blood loss. It is understood that this probably will not accurately reflect whether lack of supply might have been a contributing factor. Dr. Jennings did advise the committee that a national system, composed of the Red Cross, the Council of Community of Blood Banks, the AABB, and some smaller agencies, were working toward enhancing the recruitment effort.

The committee has also continued its review of maternal deaths in the State of Georgia. Out of 11 cases in which the review has been completed, three were identified as preventable. Attending physicians are notified of the committee's decision and any suggestions the committee has for future reference in each case.

The committee also reviewed 1980 proposed legislation relating to maternal and infant health and proposed regulations relating to the DHR billing for laboratory procedures. On the basis of committee recommendation, an Executive Committee representative attended a hearing

on the DHR proposal to bill for laboratory procedures. MAG's comments along with those of other interested parties resulted in the successful deletion of charges for any procedure that is required by law. Listed below is a statistical report from the Maternal and Child Unit of the DHR.

Livebirths and Birth Rate

There were 84,313 livebirths in Georgia in 1978. Preliminary data indicate that there will be little or no change in 1979.

Twenty-six lay midwives delivered 280 infants in 13 counties in 1978.

Certified Nurse Midwives delivered 2,518 infants in 1978.

Births to Unwed Mothers

There were 12,353 livebirths to unwed mothers during 1978, a rate of 146.5 per thousand.

Adolescent Pregnancies

Livebirths to adolescents represented 22.1% of births in 1978. There were 8,166 livebirths to mothers under age 18 out of a total of 18,595 adolescent livebirths. Of livebirths to unwed mothers, 43.9% were to adolescents under 18 or about 42.2% of under 18 teenaged livebirths were reported born out of wedlock.

Maternal Mortality

Thirteen women were reported to have died as a direct result of pregnancy during 1978 — nine black and four white. Ectopic pregnancy was the cause of death of one woman; toxemia of pregnancy was responsible or contributory in the deaths of three women; pulmonary emboli contributed to three deaths.

Abortion

In calendar year 1978, there were 34,657 legal abortions reported to the DHR; 30,152 were residents of Georgia, and 4,311 were out-of-state residents. This is an abortion ratio of 357.6 abortions per thousand livebirths. There were no deaths directly attributable to legal abortion, but one as a result of a self-induced abortion.

A total of 31.7% of women who had abortions were under 20 years of age, 64.6% were white, and 35.4% black and others. A total of 72.6% of the patients stated that they were unmarried. Over 66% reported that they were not practicing contraception prior to becoming pregnant.

Family Planning

As of June 30, 1978, there were over 100,000 women actively participating in the statewide DHR Family Planning Program. During fiscal year 1978, there was an unduplicated total of 175,790 patients served at 252,206 visits. Nearly 31% of patients were under 20 years of age. Oral contraceptives were chosen by 78.5% of the patients, intrauterine devices by 8.7%, and other methods by 12.8%.

Cervical Cancer Screening Program

During fiscal year 1979, the Statewide Cancer Detection Program sponsored by the Georgia DHR provided 119,460 Pap smears to medically indigent patients receiving health services from local county health department clinics. The Family Planning Program screened 95,825 women; 1,070 of these women had a suspicious or positive Pap smear. The High Risk Prenatal Program screened 8,500 women; 70 of these women had a suspicious or positive Pap smear. The Cancer Screening Project screened 14,315 high risk women; 118 of these women had a suspicious or positive Pap smear. Of these 1,258 women, 201 have confirmed cancer. Those malignancies found among family planning and prenatal screening clients were primarily preinvasive. Because the population served in the Cancer Screening Program was older or had other risk factors, approximately 50% of confirmed cancers were invasive.

COMMITTEE ON MEDICAL ASPECTS OF SPORTS

Paul F. Jurgensen, M.D., Chairman

The Committee on the Medical Aspects of Sports has begun activities in various areas of sports medicine in 1979. In July of 1979, a meeting was held in Augusta, Georgia, under the auspices of the American Academy of Pediatrics and included representatives of the MAG, the Georgia High School Athletic Association (GHSAA), and the Medical College of Georgia. At this meeting, a liaison was established between the Medical Aspects of Sports Committee of the Georgia Medical Society and the GHSAA. Work was begun on developing standardized comprehensive physical examination forms for Georgia high school athletes, and recommendations from the Committee on Medical Aspects of Sports on the frequency with which routine physical examinations of Georgia high school athletes should be performed.

The committee is also interested in establishing regular sports medicine seminars for high school and Little League coaches throughout the state of Georgia and is presently in the process of developing a dialogue with the Georgia High School Association to make these seminars a reality. There are several excellent seminars given throughout the state each year in cities like Augusta, Columbus, Atlanta, and Savannah, and it is hoped that these seminars can be coordinated through the Georgia Medical Society and the Georgia High School Association.

We also hope in the near future to establish contact with the Athletic Training Program at the University of Georgia to look into the feasibility of developing a manual for the fitting of athletic equipment and athletic training techniques which could be available to Little League football leagues and high school football programs throughout the state. We feel that a manual of this sort, written in easily understandable language and properly illustrated, would be an invaluable aid to coaches on all levels of athletic participation in the proper fitting of athletic equipment and could provide these coaches with training tips to prevent athletic injury.

Much work needs to be done to implement the above programs from our committee, but hopefully, we are under way.

COMMITTEE ON MEDICINE AND HUMAN VALUES

Ronald M. Hudson, M.D., Chairman

The charge of this committee is to provide information to the MAG membership about issues related to human values which affect medical practice. It will also suggest programs, activities, legislation, etc., which support the preservation of such values both in the medical profession and in the community as a whole. In pursuance of its charge, the committee met twice during the past year.

At its meeting last May, the committee discussed the subject of hospice, i.e., an approach to care of the dying which stresses humane treatment in home-like surroundings with an emphasis on the relief of pain. The committee agreed that it would work to educate Georgia physicians about their potential role in hospices. At its November meeting, the committee reviewed and endorsed an exhibit prepared by Hospice Atlanta, Inc., on the statewide development of the hospice movement. The exhibit was shown at MAG's 1979 Scientific Assembly. In early 1980, a statewide organization for hospices was formed. The committee will continue to seek effective ways of educating physicians about hospice.

Of continuing interest to the committee has been the development and fate of legislation allowing a patient to draw up a legally-binding "living will," i.e., a written directive authorizing the discontinuance of life-sustaining procedures should the patient become comatose in a terminal condition. After careful consideration, the committee 2 years ago agreed to favor such legislation, and its recommendation was supported by the MAG's 1978 and 1979 Houses of Delegates. The legislation — Senate Bill 630 originally introduced by Representative Roy Rowland, M.D., of Dublin — passed this year (1980) in the Senate Human Resources Committee but was defeated on the Senate floor. The committee will continue to study developments on this issue.

The subject of holistic health is the latest to be discussed and studied by the committee. Holistic health may be described as an approach to health care which emphasizes the individual's total state of well-being, including body, mind, emotions, and spirit. It has gained popularity throughout the country, and our committee has noted the recent development of holistic health centers in Georgia. These centers feature a variety of health practitioners and traditional and non-traditional health services. During the coming year the committee plans to study this subject in more detail and to draw up a position statement on holistic health which might help MAG members to better understand and assess the phenomenon.

MENTAL HEALTH COMMITTEE

Kenneth D. Jones, M.D., Chairman

The make-up of the MAG Committee on Mental Health is as follows: William S. Davis, M.D., Atlanta; Mark A. Gould, M.D., Smyrna; M. Brannon Sell Jr., M.D., Augusta; Luther J. Smith, II, M.D., Columbus; Corbett H. Turner, M.D., Atlanta; David Allen Turner, M.D., Albany; Robert Van de Wetering, M.D., Atlanta; Frank A. Wilson III, M.D., Leslie; A. S. Yochem Jr., M.D., Atlanta.

The entire make-up of this committee, with the exception of Dr. Wilson, are psychiatrists and are members of the Georgia Psychiatric Association (GPA).

The MAG Mental Health Committee did not meet during this past year due to the fact that there was not a need for a committee meeting. The GPA has numerous committees which look into all mental health problems that arise throughout the state. The GPA knows of the existence of the MAG Mental Health Committee and is well aware that the MAG is here to assist the GPA on any and all areas of concern regarding psychiatrists and mental health in Georgia.

The liaison between the MAG and the GPA could not be better. For this reason, there has not been a need for the MAG Committee on Mental Health to meet; however, we do hope the committee will remain intact, for in the future the GPA will be calling upon the MAG and the MAG Mental Health Committee to assist in regard to mental health in Georgia.

OCCUPATIONAL HEALTH COMMITTEE

Robert P. Cunningham, M.D., Chairman

The Occupational Health Committee met on several occasions in 1979 and was concerned primarily with questions relating to the Worker's Compensation Act which became effective in July, 1978. The interpretation of this Act continues to raise questions and to be a source of confusion for many physicians throughout the state. The committee endeavored to provide direct answers to specific questions from physicians and to attempt to further clarify the Act. Section 114-822 of the Act calls for MAG to furnish the Governor with a list of physicians from which he will make appointments to the Medical Board of the Worker's Compensation Board. The Medical Board considers all questions relating to occupational *disease* as opposed to occupational *injury*. The committee furnished the Executive Committee with names of physicians recommended for appointment and these were then sent to the governor.

PHYSICIAN-LAWYER LIAISON COMMITTEE

William E. Huger Jr., M.D., Chairman

The Physician-Lawyer Liaison Committee has been fairly active in the past year. It has met with committee members from the Georgia State Bar at which time certain activities were planned, but the final guidelines not established.

In particular, two activities are underway, the most important of which is rewriting the pamphlet entitled, "Principles Governing Physician-Attorney Relationships." In addition, we are investigating the use of Professional Liability Arbitration Panels. These two activities will be coordinated with the activities of the Professional Liability Committee.

To date, only two physician-lawyer disputes have arisen. Hopefully, they can be settled, as in the past, on an informal basis.





What did John Heard (R) say to DeKalb Medical Society's Executive Director, Hank Holderfield?

COMMITTEE ON PRISON HEALTH CARE

Charles Allard, M.D., Chairman

The committee has continued to grow this year with the addition of two physicians who have expressed particular interest in this committee's work and an attorney by request of the committee chairman. The committee has met four times in the year. Committee members have expressed continued commitment to the work of the committee and support of the AMA program. Additionally, the AMA has publicly expressed a commitment to continue involvement in correctional health care and accreditation of facilities meeting Standards. Funding is expected to continue through June, 1981, and plans for further proposals have been made. In this year of the project, 12 new jails have entered into participation in the AMA program. This makes a total of 25 jails in the State of Georgia that have been involved in the project at one time or another during the past 3 years.

This year has seen the exchange of the committee's chairman. Dr. Haverty, after 3 years of serving as chairman, resigned but still remains as a member. Dr. Charles Allard of Decatur was appointed as the new chairman on June 1, 1979. At about that time, the first 3-year contract with AMA ended and a new contract for $43,650 has been entered into by the MAG and this committee.

The committee members have entered into a number of activities during the year. Dr. Haverty was appointed to the Governor's Study Commission on Georgia Jail Standards and was very active in the development of the Georgia Jail Standards, which are now published. These Standards were presented by the Governor to the Legislature in the past session and were passed as voluntary standards for all Georgia jails. Dr. Allard has been active in making presentations at the Kiwanis and Lions Club about the program, and on Jan. 15, 1980, made a presentation at the Peach Belt Medical Society in Perry, Georgia. Another member of the committee, Dr. Hertell, has made several visits to prisons and jails in Kentucky and Florida and has made official reports to the authorities in those states on his findings. Dr. Carson Burgstiner of Savannah also visited the Chatham County Jail for the purpose of evaluating the health care system there. All members of the committee are available on a voluntary basis to provide this service as needed. Drs. Bennett and Bliven, both committee members, have expressed an interest in developing a program in one of the medical schools which would provide some experience in providing health care in correctional institutions for medical students. Finally, Dr. Allard was nominated by the AMA to participate on the National Advisory Committee on Accreditation as it forms a new committee this year.

The AMA contract this year provided for technical assistance to be given to the participating jails and is being provided in several ways, one way being training. In December, 1979, a workshop was held in Macon for all participating jails to write procedure manuals. The manuals contain procedures which help the jails to comply with AMA standards. Additionally, the manuals were able to be computerized which helped to speed up the process in meeting the standards on written procedures. In the past, this task alone has required several months of effort for the jails, and in some cases were not completed. The computerized manuals have greatly improved this stumbling block. In February of this year, there was a 3-day training workshop held at Mercer University in Macon for correctional officers entitled, "Abnormal Behavior in the Correctional Setting." Again, training was directed towards helping the jails comply with AMA Standards in regard to recognition of symptoms which require medical attention. The Committee also sponsored its Second Symposium on Health Care in Correctional Institutions in Savannah at the Memorial Medical Center on April 12, 1980. Four panels addressed particular problem issues in correctional health care such as legal issues, chemical dependency, mental health, and pharmaceutical controls. The Chairman and staff also participated in the AMA's Third Annual Conference in Chicago in November, 1979. A presentation was again made about the receiving screening course developed by this committee and requests for materials and audio-visual aids continue to be received from outside the State of Georgia.

The development and testing of the *AMA Standards for Health Care in Correctional Institutions* continues to be a major activity of this program. All participating jails have been evaluated at least twice this year to establish their rates of compliance with AMA Standards. Much improvement was noted when compared to former years. Ten Sheriffs have expressed an interest to participate in accreditation site visits sometime before or in June of this year. Most of these are showing substantial compliance to Standards. At the present time, there are three county jails which are accredited by the AMA. They are Monroe,

Cobb, and Chatham counties. During the past year project staff have consulted on accreditation site visits in Orange County, Texas, and Mobile, Alabama. Both of these jails were subsequently accredited for 2 years each by the AMA. Two jails from prior years, Chatham and Richmond, are expected to re-apply for accreditation site visits before June. A new procedure to charge accreditation fees for site visits is being implemented by the AMA's National Advisory Committee this spring. Other project activities have included assisting the jails to find physicians to provide care and also informing the local medical societies of the program activities.

Another major activity of the staff this year has been collection of inmate and systems data from 24 jails which are located in the North Central Georgia HSA area. This has been a collaborative effort between the HSA and the MAG. The analysis of the data will be based on the AMA Standards as they were at the time of the data collection. About 275 inmates were interviewed during the spring of 1979. The activity during the survey provided educational opportunities for several students in health delivery systems analysis. Additionally, it is providing the committee with an opportunity to make needed recommendations in this important area of health care and to affect planning policy for this area of Georgia.

Again, it seems that the project's funding will continue for another year. Latest reports are that the Law Enforcement Assistance Administration will not be continued after October of 1981 which means that the AMA will be seeking new sources of funding to continue the work in this area. AMA has repeatedly reaffirmed its commitment to the continuation of this endeavor. The committee has demonstrated its sincere commitment to the program's goals and progress continues to be made evident within the State of Georgia by the improvement of health care delivery in the county jails through the efforts of this committee. We believe that the MAG must continue its active involvement in this cause as a recognized responsibility of the medical profession for the communities in Georgia.

AD HOC COMMITTEE ON RISK MANAGEMENT

John Rhodes Haverty, M.D., Chairman

In the summer of 1977, the Executive Committee established a committee to look into the possibility of developing a risk management seminar. The committee originally consisted of Carson B. Burgstiner, Chairman; William W. Moore; and James A. Kaufmann. A report was given to the Board of Directors in September, 1977, where it was stated that discussion would take place regarding the seminar with the St. Paul Companies.

Other than occasional conversation about the issue, nothing more was done until the Executive Committee meeting of August 13, 1978, when Dr. Burgstiner stepped down as chairman, and Rhodes Haverty was appointed chairman of the committee.

Some continued sporadic conversations took place over the next several months, but in July, 1979, activity began again in earnest when a group went to St. Paul, Minnesota, to discuss the idea further with officials of the St. Paul Companies.

Following this meeting, more planning took place, and in November, 1979, a developmental meeting of MAG members, attorneys, insurance executives, a judge, and others was held for the purpose of ascertaining and prioritizing causes for liability claims. A final list of 17 major areas was the result, and based on this listing, development of a curriculum for a seminar was begun.

Presently, it is felt that the curriculum can be finalized in April, 1980, and that the first, pilot seminar can be given in June, 1980. It is anticipated that the pilot group will consist of some 50 participants, in addition to the faculty and staff necessary.

St. Paul has agreed to fund the development of the workshop. It is expected that the workshops will be self-supporting. The workshops will be given around the state after the "bugs" are worked out following the first pilot effort. St. Paul has agreed to having a discount in malpractice premiums for those physicians who complete the workshop successfully. It would be anticipated that there would be a nominal charge for MAG members to attend, and a substantial charge for non-members.

It is hoped that this will result in one of those delightfully satisfying situations where everyone wins. If the program is successful in its objectives, the number of malpractice claims should be reduced for those physicians who participate in the workshops. This obviously will be beneficial for physicians and the St. Paul Companies alike. Additionally, because of the differential in fees for the workshop, it is hoped that MAG members will be appreciative of receiving services because they are members, and that the MAG will in fact benefit by recruiting additional members.

More information may be available at the Annual Session. You will be hearing more from this group over the next several months.

COMMITTEE ON SCIENTIFIC ASSEMBLY

Arthur J. Merrill Jr., M.D., Chairman

For the fifth consecutive year, the MAG's Division of Education organized and sponsored the MAG Scientific Assembly, held November 15-18, 1979, at the Omni International Hotel in Atlanta. In a day when competition among medical meetings is getting stiffer, MAG's Scientific Assembly is showing remarkable signs of success. Attendance this year was 943, an increase of over 50 from the previous high for an independent MAG meeting. Included in the figure are 518 MAG members who paid a registration fee and many other non-paying members who were program chairmen or speakers. Our thanks should go to the Assembly Chairman, Mark M. Lindsey, M.D., and the Committee on Scientific Assembly, who worked so capably in planning the meeting. Special thanks should also go to MAG's Director of Education, Stephen Daniel, Ph.D., and his former assistant, Miss Sue McAvoy, who labored tirelessly behind the scenes coordinating all the details.

The 1979 Assembly included simultaneous scientific

sessions in 16 specialties, with 19 state and local specialty societies doing the planning. Each society was represented by a program chairman. This pioneering format allows for interchange among the many diverse segments of organized medicine and demonstrates the unity of the profession on the value of continuing education. As in the past, the MAG provided publicity, meeting space, audiovisual equipment, registration services, and speakers funds for the programs.

The 1979 Calhoun Lecturer was Edmund D. Pellegrino, M.D., President of the Catholic University of America in Washington, D.C., whose address, "Medical Economics and Medical Ethics the Growing Conflict," was very well received. An MAG reception followed the lecture.

Two special educational programs were featured at this year's Assembly. The Georgia Chapter of the American College of Physicians, in cooperation with the Georgia Health Sciences Library Association, sponsored a seminar on, "Recent Advances in Medical Information Transfer and Technology." The seminar drew 100 physicians and librarians for discussion of the role of technology, clinical data banks, and medical journals in continuing medical education.

The four medical schools in Georgia and the MAG's Committee on Education sponsored a Conference on Medical Education, the first such statewide conference since 1976. Participants heard the deans describe the priorities and philosophies of medical education at their respective schools and then heard MAG President, Earnest Atkins, M.D., address the topic of the MAG's goals and priorities. The Scientific Assembly appeared to be a good occasion for the Conference.

Following is a demographic breakdown of registrants, excluding out-of-state guest speakers: Atlanta area 566, Augusta 71, Macon 22, Columbus 29, Savannah 31, smaller towns in North Georgia 98, smaller towns in South Georgia 44, and out-of-state 55.

The amount budgeted for the Assembly was $19,905.00. Actual expenditures were $26,418.35. Since gross receipts (including registration fees and contributions from pharmaceutical firms) totaled $20,560.00, the cost of the meeting to the MAG was $5,858.35 — less than 30% of the amount budgeted.

Included in expenditures was $12,500.00 for the educational programs of the various specialty societies. The committee regards these "speakers funds" as essential to the participation of the specialty societies, the quality of the education offered, and the overall attendance at the Assembly.

1980 Assembly

MAG's 1980 Scientific Assembly will be held November 21-23 at the Omni International Hotel in Atlanta. The 1980 Chairman is Arthur J. Merrill Jr., M.D., of Atlanta. Twenty-one specialty societies will be participating, including two which have not sponsored specialty programs in the past: the Georgia Orthopedic Society and the Georgia Society of Otolaryngology. In addition, the MAG Committee on Nutrition will be sponsoring a general session on nutrition.

TRUTHFUL ADVERTISING COMMITTEE

Richard E. DuBois, M.D., Chairman

The committee met on one occasion to differentiate medical advertising into two categories. The first was that by chiropractic and the second encompassed all others.

At this time, the committee feels it should only respond to complaints about advertising, and it has no plans to set up monitoring activities of either category of advertising.

Having received no complaints, the committee has not met again.

WOMEN PHYSICIANS IN ORGANIZED MEDICINE

Lois T. Ellison, M.D., Chairwoman

The Committee on Women In Medicine was appointed in the Fall of 1979 by the Executive Committee. The charge to the committee is to undertake a study of women physicians in organized medicine and to make recommendations on how to promote and advance greater involvement for them in all aspects of organized medicine.

The committee has met once this year to identify reasons why women physicians are not greater involved in their county societies, the MAG, and the AMA. The committee is also looking at ways: to identify those women physicians who are practicing in Georgia but not members; to encourage those who are members to be more active; to approach women physicians on housestaffs to educate them as to the benefits of joining organized medicine; and to contact women medical school students to encourage future membership.

The committee agreed that the reasons for minimal active participation by women in MAG and at the county society level were not because of any discrimination or prejudice.

The committee will be polling the state's women physicians to explore the levels of their participation in organized medicine; to ascertain why they are not more involved; to inquire if there are feelings of what is needed to get them more active.

There are 190 women physicians in MAG, or about 4% of MAG's total members. We are concerned that there are no women on the Executive Committee or the Board of Directors and only one or two women members in the House of Delegates. Again, we feel it is the responsibility of the committee to encourage stronger participation.

The committee will also be contacting other state associations and the AMA to see what levels of participation they have from women and what they are doing about it.

The committee wishes to commend the Executive Committee for the foresight in seeing the need for such a committee. As approximately 25% of students entering medical schools are women, participation by women in medicine will accelerate rather rapidly. We trust that their involvement in organized medicine will do likewise.

THE GEORGIA MEDICAL CARE FOUNDATION

Michel A. Glucksman, M.D., President

The Georgia Medical Care Foundation held an election of the Board of Directors during April of 1979. The following physicians were elected to the Board:

District 1: Joe L. Nettles, M.D., Director, Michel A. Glucksman, M.D., Alternate Director; **District 2:** Frank R. Miller, M.D., Director, John G. Bates, M.D., Alternate Director; **District 3:** George F. Armstrong Jr., M.D., Director, E. Harry Brown, M.D., Alternate Director; **District 4:** Harry R. Foster Jr., M.D., Director, Hutson H. Carspecken, M.D., Alternate Director; **District 5:** Charles E. Harrison, M.D., Director, L. Newton Turk, III, M.D., Alternate Director; **District 6:** Kenneth H. Reynolds, M.D., Director, W. Ernest Barron, M.D., Alternate Director; **District 7:** Richard A. Griffin III, M.D., Director, J. Paul Ferguson, M.D., Alternate Director; **District 8:** Jack F. Menendez, M.D., Director, Leonard C. Durrence Jr., M.D., Alternate Director; **District 9:** James A. Butts, M.D., Director, Louis G. Cacchioli, M.D., Alternate Director; **District 10:** Luther M. Thomas, M.D., Director, Donald L. Branyon Jr., M.D., Alternate Director; **Osteopathic Representatives:** Darrell L. Dean, D.O., Director, E. Scott Leaderman, D.O., Alternate Director.

At its next meeting, the Board elected the officers for 1979-80, resulting in Michel A. Glucksman, M.D. being elected President, Louis G. Cacchioli, M.D., Vice-President, Joe L. Nettles, M.D., Secretary, and Frank R. Miller, M.D., Treasurer.

Two standing committees were appointed: the Finance Committee, consisting of Frank R. Miller, M.D., Louis G. Cacchioli, M.D., and Harry R. Foster Jr., M.D.; and, the Liaison Committee consisting of Joe L. Nettles, M.D., Richard A. Griffin, M.D., Louis G. Cacchioli, M.D., and L. Newton Turk III, M.D. The Liaison Committee is a new committee established to maintain effective communications with the Metro Atlanta Foundation for Medical Care.

Staff changes during the year included the hiring of our current Hospital Financial Liaison and Data Manager, Mr. Tom Williams. Additionally, upon the resignation of Ms. Lyn Myers from the PSRO program, Ms. Anita Anderson was appointed as the Program Director for PSRO in addition to her duties in managing the Physician and Hospital Review Departments. With this appointment, the Foundation was re-organized into two main program departments, the Long-Term Care Department and the Acute and Amblatory Care Department. The PSRO project falls within the purview of the Acute and Ambulatory Care Department.

LONG-TERM CARE DEPARTMENT

On-Site Utilization Review Program

Over the past year, the On-Site Utilization Review teams have completed two total reviews of all Medicaid recipients residing in 307 long-term care facilities in the State of Georgia. This total number (307) is comprised of all skilled and intermediate nursing home facilities presently providing care for Medicaid recipients in addition to those facilities providing continued care at the intermediate level for the mentally retarded.

Approximately 25,305 recipients were reviewed on a semi-annual basis by the on-site review teams over the past 12 months. The reviews were conducted by 11 teams located throughout the State of Georgia. Each team is composed of a registered nurse, a social worker, and a physician.

In addition to the semi-annual on-site reviews, an interim review is conducted for each Medicaid recipient at the skilled level of care at least twice a year. The interim reviews are scheduled to occur midway between the on-site reviews. The interim reviews are conducted at the Foundation offices by registered nurses.

Pre-Admission Certification Program

The purpose of the Pre-Admission Certification Program is to determine both the medical necessity and the appropriateness for admission to a long-term care facility for all Medicaid recipients in the State of Georgia who are seeking placement in a nursing home. This program is also addressed to the placement of the Medicaid recipient at the appropriate level of care upon admission to a nursing home. Pre-admission certification is required for each new admission of a Medicaid recipient to a skilled or intermediate care facility in Georgia, in addition to each transfer from one nursing home facility to another.

Pre-admission certification may be applied for through the mail or obtained by telephone. Telephone pre-admission certification of nursing home residents has experienced a notable growth during the past 12-month period from 10,000, as of January, 1979, to a total of nearly 12,000 requests for placement being processed as of January, 1980.

All health care provider agencies have access to the telephone pre-admission certification service by calling the toll-free WATS number 1-800-282-4575.

Nursing Home Bed Registry Program

The Nursing Home Bed Registry was developed to assist health care providers in their efforts to locate the closest available nursing home bed vacancy at the appropriate level of care for persons requiring placement.

During the past 12-month period, approximately 1,200 calls were received on the toll-free WATS number, 1-800-282-4573, from locations throughout the State of Georgia.

In order to keep the registry information current, the Foundation contacts each facility by telephone on a predetermined day of each week. Appropriate information is obtained by the Registry, and made available to assist health care providers in expediting the placement of persons under their care into available nursing home facilities.

Medical Care Evaluation Studies

The Long-Term Care Department conducts on-going annual Medical Care Evaluation Studies as an integral part of quality assurance monitoring in the nursing home review process. The purpose of the studies is to identify and evaluate various aspects of long-term care, both administrative and patient care related. The studies are conducted on all Medicaid recipients residing in nursing homes at the skilled level of care. The data is compiled and tabulated by the Foundation. The results of the studies are made available to the appropriate facilities for informational, educa-

tional, and related purposes. Appropriate recommendations are then made regarding possible approaches to any issues identified as the results of the studies.

Home Health Care Review Program

The Home Health Care Review Program was initiated in 1978 in order to monitor and evaluate services provided to Medicaid recipients by the non-profit home health care agencies in the State of Georgia. The program is designed to assess the appropriateness of services provided to Medicaid recipients as to necessity, quality, adequacy, and effectiveness.

Since the initiation of this program, the number of home health care agencies providing care to Medicaid recipients has increased from 14 to 58. Three record reviews are conducted each year, with a total of 1,335 records having been reviewed this past year. Approximately 20% of the Medicaid recipients active in the program received home visits by the registered nurse conducting the reviews.

Alternative Health Service Review Program

The Alternative Health Service Review Program was developed in 1978 to monitor and evaluate services provided to Medicaid recipients receiving an expanded range of health and social services in the community setting through the Alternative Health Services Project. Presently there is a total of 28 agencies providing alternative health services throughout a 17-county area in Georgia, extending from the Athens to the Atlanta area.

Three record reviews are conducted each year, with a total of 2,175 records being reviewed annually. Of these 2,175 records, 1,584 represents the number of active clients presently reviewed by this program.

Services such as home-delivered health care, home-delivered meals, and homemaker services are available to those clients who qualify for nursing home placement, but prefer to remain in the community setting. Fifty percent of the clients active in the program receive home visits by the registered nurse conducting the reviews.

Long-Term Care Program Activities

The 10-member Long-Term Care Specialty Panel has met bi-monthly over the past year to discuss policy, criteria, and patient review.

Two Foundation conferences have been held this past year for members of the on-site review teams. The first conference was held on June 28 and 29, 1979, at the Atlanta Hilton; the second was held at the DeSoto Hilton on January 31, 1980, and February 1, 1980, in Savannah, Georgia. The purpose of the conferences is both educational and informational. Persons from various aspects of the health care field are invited to attend these conferences and while at these conferences, to make presentations relating to long-term care, in order to provide a form of continuing education for the on-site team members. During the conferences, team members are given information regarding changes in Foundation policy.

Members of the Long-Term Care Department have attended numerous workshops and seminars, and made presentations to various groups over the past year.

This department has again successfully passed the Department of Health, Education, and Welfare's operational requirements for continuation of the utilization review waiver as well as an operational on-site and in-house review audit. This places the Department of Medical Assistance in total compliance with the Department of Health, Education, and Welfare requirements for Long-Term Care review.

ACUTE AND AMBULATORY CARE DEPARTMENT

Physician and Hospital Services

The 14 Specialty Panels functioned within the Foundation, dealing with both physician and hospital matters, as needed.

In the physician area, Medicaid and Prudential Part-B patterns of practice were reviewed by the appropriate Specialty Panels. Commercial claims continued to be reviewed. Special reviews were conducted for Medicaid upon request.

Early in the year, the Foundation began a computerized review program for Medicaid. Claims representing various diagnoses and procedures were reviewed, as well as a percentage of short-term stays. The processor for this program is the MAG Information Systems.

The Psychiatric Guidelines were completed and approved by the Foundation. The remaining *Guidelines for Use In Peer Review* received Panel review.

The Podiatry Panel met with Medicaid on various occasions for the purpose of surveying procedures billed to Medicaid and to design computer parameters to assist with Podiatric review.

PSRO

The PSRO received its conditional designation status and grant effective July 1, 1979. The obligatory date set for the beginning of binding review was October 1, 1979. Immediately, communication was initiated to negotiate fiscal arrangements to reimburse those hospitals which wished to be delegated to perform their own peer review. At the same time, workshops were scheduled and held throughout the state to provide information regarding the Foundation/PSRO itself, the financial aspects relating to the hospitals, utilization review, and Medical Care Evaluation Studies.

With a Congressional cap placed on the amount available to implement PSRO nationwide, the GMCF/PSRO was informed in mid-September that it could not proceed into binding review until further notice. This has not changed to date.

The GMCF/PSRO was permitted to proceed with its data system, and bids were accepted from various data processors. Using an objective weighing system, as well as an outside consultant, the contract was let to the MAG Information Systems and approved by HEW. The programing process was begun toward the end of the year. The PSRO staff worked on further study and refinement of the program and its many aspects.

As we are informed that Oct. 1, 1980, is our new implementation date, the staff of the Foundation are once again planning educational efforts for hospital personnel regarding the workings of PSRO. During the spring of 1980, it is intended that presentations be made to the Georgia Hospital Association District meetings in order to inform hospital administrators. During the spring and

summer, agreements will be made with the hospitals as to their delegated status and financial arrangements. In the latter part of the summer or early fall, informational workshops will be conducted for those physicians who will be participating in the program as advisors and will be principally handled by the members of the Medical Advisory Committee to the Board of Directors.

It is hoped that the process of implementation this year will be far more orderly than it could have been last year due to the more reasonable time-frame which will be in evidence this year.

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Edgar Woody Jr., M.D., Editor

In 1979-80, the *Journal* staff has continued in its efforts to be responsive to the needs and desires of our readers. The May issue was devoted entirely to teenage pregnancy in Georgia. More letters to the editor were received following this issue than at any time in the past. Needless to say, such a demonstration of interest by physicians and their wives was very gratifying. The June issue featured the ethical pharmaceutical industry. An unusual item in this issue was an historical article concerning John Hunter and two Cherokee Indians. In September, the timely issue of drinking during pregnancy was featured in two scientific articles, and an editorial was devoted to the subject. This issue was used by a special Task Force of the Georgia Department of Human Resources as part of its education program for a statewide effort to increase public awareness about fetal alcohol syndrome. The October issue outlined the multiple facets of MAG's activities on behalf of its members. Also in this issue, an editorial featured the National Health Service Corps, with a discussion of its significance. In the December issue, Certificate of Need was discussed, showing how it is affecting the practice of medicine in Georgia. The February issue featured the upcoming Annual Session in Atlanta in April, a clinicopathological conference from the Medical College of Georgia, as well as a timely editorial on the subject of Health versus Radiation Hazard. The March issue featured the thought-provoking issue of medical economics and medical ethics, the topic of the Abner W. Calhoun Lecture delivered by Dr. Edmund Pellegrino. An historical article was presented relating to mortality rates among troops in the Civil War. An interesting account by one of our members of a transatlantic voyage via a sailing yacht kindled excitement and a vicarious thrill in many of us.

Credits

Our contributing editors have been most supportive in helping us obtain and screen suitable material for the *Journal*. Three valuable additions to our roster of contributing editors are Jack A. Raines, William R. Kenny, and Carson B. Burgstiner.

The monthly contributions of Dr. Earnest Atkins for his "President's Letter" have been cogent and timely.

It was with much regret that we accepted the decision of Dr. J. G. McDaniel to discontinue his popular feature page, "I've Told This Before." His past contributions have been a great asset to our publication.

The Executive Committee of the Board of Directors, which also functions as our Publications Committee, has, as always, been helpful in guiding the affairs of the *Journal*. Our Heart and Cancer Pages have continued to provide us with superior copy. The Legal Page, authored primarily by Robert N. Berg, has kept us informed regarding timely legal commentaries.

Our innovative and creative cover artist, Richard Lyons, continues to produce attractive and descriptive covers month after month.

The fine contributions and useful input by members of the headquarters office staff constitute an essential element in the production of each issue of the *Journal*.

Personnel

Ms. Mary Coté has resigned as our advertising representative. There have been no other changes in our personnel connected with the *Journal* in the past year. I believe we have a winning team and expect to keep it that way.

Local Advertising

New plans for increasing the thrust of our local advertising solicitation are already in effect. Out of necessity, we have increased our economic goals to help offset the rapidly rising cost of printing.

State Medical Journal Advertising Bureau

Since last year our national advertising volume has remained stable. The Williams & Wilkins Company of Baltimore has continued to do an excellent job as our national sales force for the Bureau. Your editor continues to serve as a member of the Board of Directors of the Bureau.

National Award Received

Your editor and managing editor are happy to report receipt of a letter on February 27, 1980, announcing an award to our *Journal* of first prize in a national competition among state medical journals. The award includes an appropriate certificate and a check for $500. We are indebted to Sandoz Pharmaceuticals for this much appreciated citation.

NEW BUSINESS

The Speaker proceeded to new business, calling for the introduction of Resolutions.

R1: Legal Approval of MAG Resolution
R2: Medicaid Complaint
R3: Finance Charge for Medical Billing
R4: Health and Safety of High School Athletes in the State of Georgia
R5: Robert Cumming Wilson
R6: Welfare of the Patient
R7: Involvement in Medical Issues
R8: Control of Nurse Practitioners in Medicine
R9: Expansion of Medical Schools
R10: Current Procedural Terminology-IV
R11: Membership of the American Medical Association
R12: Implementation of Malpractice Insurance Program

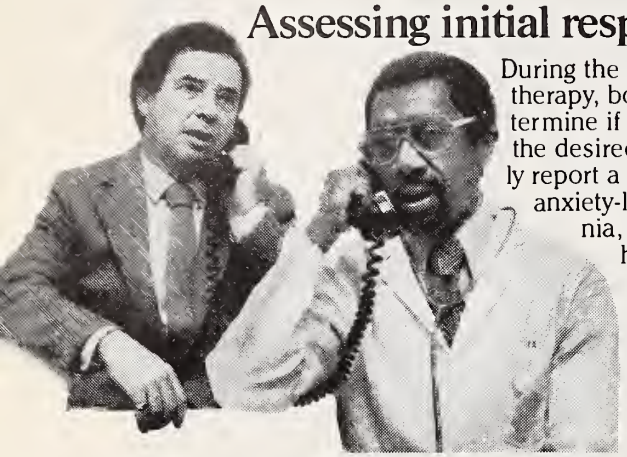


Drs. Carson Burgstiner, Savannah; AMA President Hoyt D. Gardner, Louisville, Kentucky; Mr. O. W. ("Bud") Wright, Associate Director of AMA's Office of Medical Society Relations, Chicago, Illinois; Drs. Harrison L. Rogers, Jr., Atlanta; and L. Newton Turk, III, Atlanta, take a break during one of the Sessions.

R13: Reimbursement by Third Party Payment Agencies
R14: Status of Efforts to Revise the Medicaid Provider's Manual
R16: MAG Officers
R17: Catastrophic Health Insurance
R20: Repeal of Section in Georgia's Worker's Compensation Laws Dealing with the Selection of Physicians
R21: Preferential Immigration Status of Physicians
R22: Disapproval of Supporting of Single Health Care Delivery Systems
R23: Rural and Urban Health Clinics
R24: Amending Section 9, 114-504, Selection of Physicians
R25: Out-Patient Insurance
R26: Position Statement on Health Maintenance Organizations

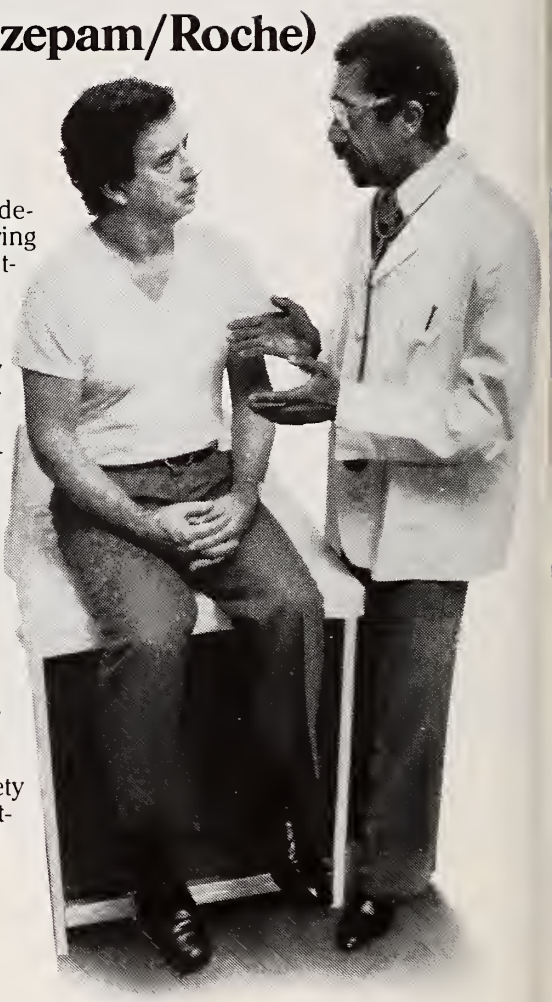
Following brief announcements by the Speaker concerning Reference Committees and the election of officers on Sunday, the First Session of the House of Delegates was adjourned at 10:40 PM.

Monitoring patient response to Valium® (diazepam/Roche)

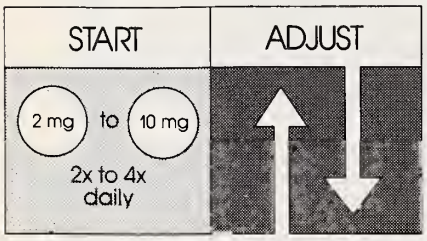


Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments



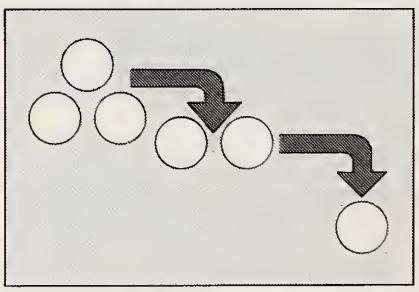
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

2-mg, 5-mg, 10-mg scored tablets

Valium® (IV) diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

ROCHE®

See the following page for a summary of product information.

Valium®(diazepam/Roche)℞

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

ROCHE®
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

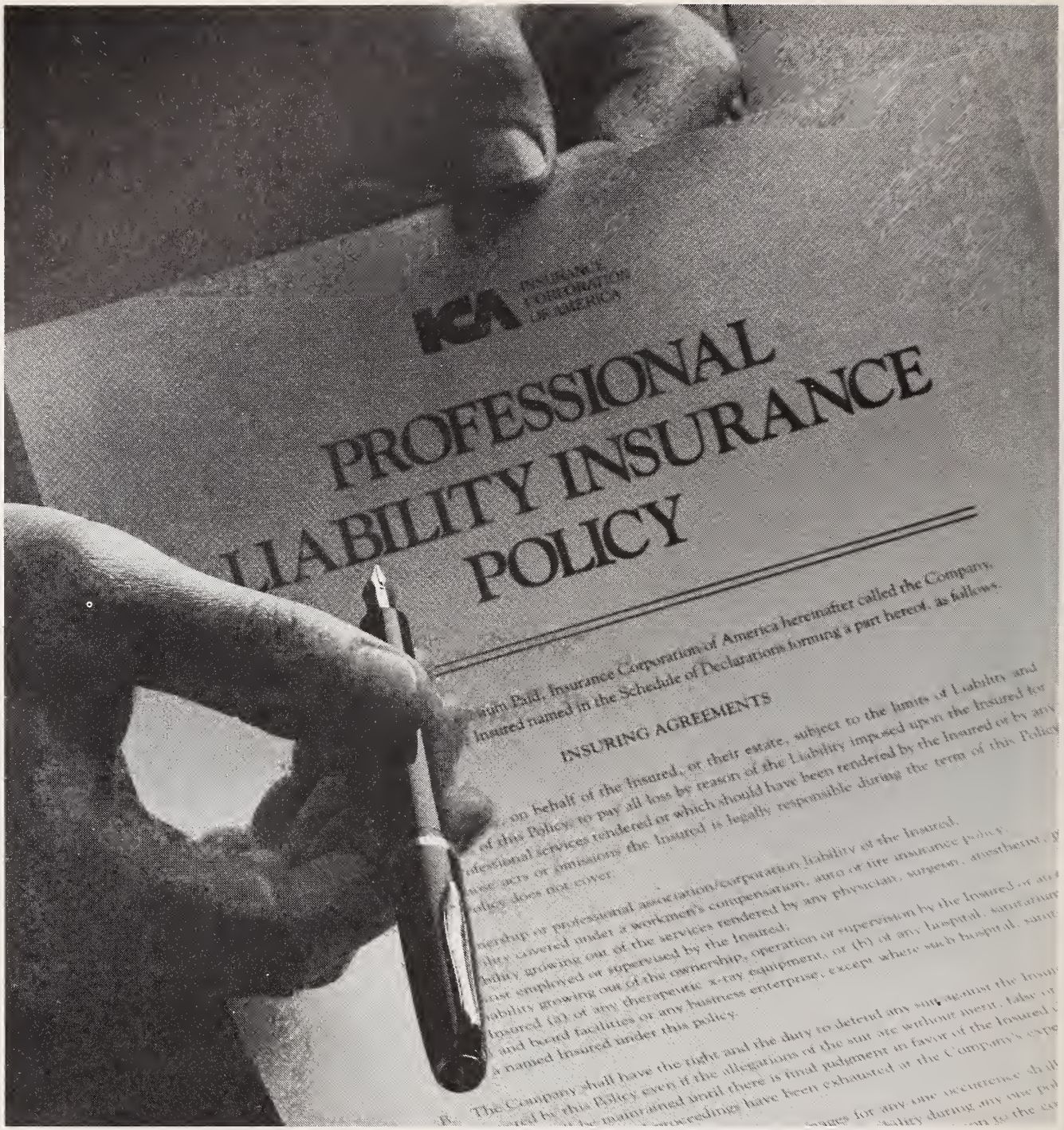
W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339



PUT A CONTRACT OUT ON FRIVOLOUS CLAIMS.

Frivolous claims can be a nightmare. Especially if your malpractice insurance company doesn't stand by you. And unfortunately, all too many don't.

For instance, most malpractice insurance policies give you no say in whether to fight or settle a claim. And if you do have a say, you can be hit with a costly penalty for going to court. Another thing. Many companies don't pay all legal expenses. And most companies seldom use lawyers to process cases. Claims are often handled only by claims adjusters.

It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working for doctors. So we know the strong coverage and knowledgeable service physicians need from their liability insurance. And since we specialize in this one field, we can offer a superior policy for a realistic premium. Premiums based on actual costs in your state.

So select the policy with the protection you need. Put a contract out on frivolous claims. For more information contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas Phone 1-800-231-2615

ICA INSURANCE CORPORATION OF AMERICA

MALPRACTICE INSURANCE IS BETTER TODAY. BECAUSE OF ICA.







(Above): Dr. Hoyt Gardner, President of the AMA, brings greetings from that organization. (Top left photo, L-R): Mrs. Miriam McLendon, Mr. James M. Moffett, Drs. William D. Logan, Jr., Jack F. Menendez, and L. C. Buchanan attend to the business of the Third Session of the House of Delegates. (Bottom left): Dr. H. Hilt Hammett, Jr., pays tribute to the late Dr. J. W. ("Red") Chambers of LaGrange for his many contributions to the MAG and organized medicine. L. C. Buchanan (R) listens.

Second Session, House of Delegates
Saturday, April 26

The Second Session of the House of Delegates of the MAG's Annual Business Meeting was called to order at 10:00 AM, on Saturday, April 26, in the Grand Ballroom of the Atlanta Hilton Hotel by Speaker L. C. Buchanan of Decatur.

Following preliminary announcements, Dr. Buchanan called on Dr. William C. Logan, MAG Secretary, for the presentation of Certificates of Appreciation to the following: Representative Dorothy Felton, Atlanta; Senator Richard Greene, Macon; Senator E. Culver Kidd, Milledgeville; and Mr. M. Virlyn Slaton, Atlanta.

Dr. H. Hilt Hammett Jr., President-Elect paid a special tribute to the late Dr. J. W. Chambers for his innumerable contributions to organized medicine, MAG, and the medical profession in general during the length of his professional career.

Via a special conference telephone hook-up, Speaker Buchanan presented a Certificate of Appreciation to Mrs. Lola Inman Brown who responded to the House from her home.

Speaker Buchanan called on Dr. Earnest C. Atkins for the purpose of introducing the featured speaker, Dr. Hoyt Gardner of Louisville, Kentucky, President of the AMA. Dr. Gardner addressed the House of Delegates generally on the subject of what the AMA is and what it does.

The Speaker asked for a report on attendance from the Credentials Committee and Dr. Virgil McEver reported that there were 163 Delegates present, and that accordingly, a quorum did exist.

Delegate Jack Raines asked permission for Dr. Kenneth Olds from Colorado to address the House of Delegates briefly concerning Health Maintenance Organizations.

REFERENCE COMMITTEE REPORTS

Speaker Buchanan called for reports from the Reference Committee Chairmen. The Speaker reiterated the previously given procedure that would be followed in the presentation of Reference Committee reports and then proceeded to call for Reference Committee reports in the following order: Reference Committee A, Reference Committee D, and Reference Committee F.

The Complete Communication Company...

OFFICE COMMUNICATIONS INCORPORATED*

ne Portables



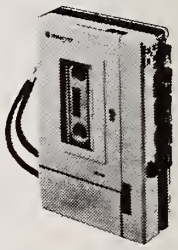
NORELCO
NT-1



NORELCO
185

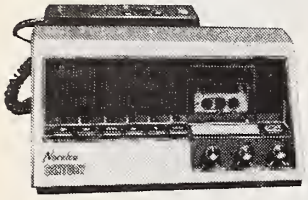


DORO
706

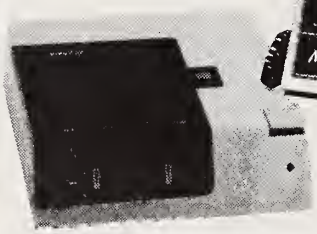


SANY
1500

Desk Top Dictation/Transcription Systems



NORELCO
CENTURY

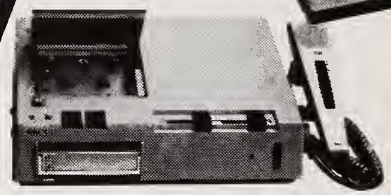


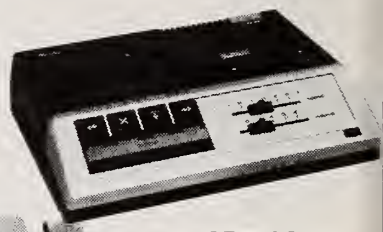
DORO 707



DORO 705

NORELCO 102



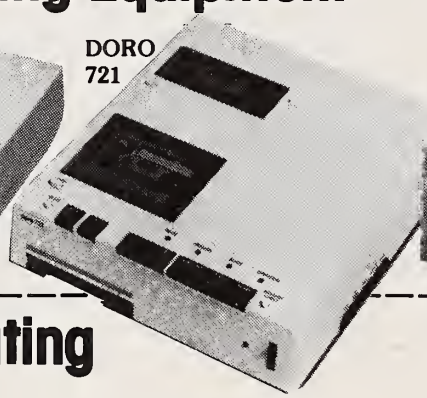


NORELCO 186

Phone Answering Equipment



SANYO
139



DORO
721

DORO
320



SANYO
9908

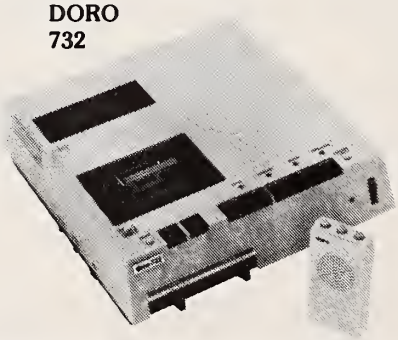


Telephone Dictating

NORELCO
260



DORO
732



*One Stop Communications Sales and Service...

OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry: Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service department throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED
6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741



Members of Reference Committee A (L-R), Mr. Ken Williams (MAG Staff), Drs. Eloise Sherman, Savannah, Chairman; Robert Wells, Atlanta, Vice-Chairman; Charles McDowell, Jr., Decatur; Donald Manning, Brunswick; and J. R. Turner, LaGrange, listen to a discussion regarding the report of the Speaker of the House. Not shown are Dr. Sammie Dixon, Tifton, and Bob Brown of MAG Staff.

Report of Reference Committee A

ELOISE B. SHERMAN, M.D., Chairman
ROBERT E. WELLS, M.D., Vice Chairman

Chairman Sherman reported to the House of Delegates that the reports and resolutions referred to Reference Committee A, which met in the Cabinet Room, Atlanta Hilton Hotel, Atlanta, Georgia, on April 24, 1980, were carefully considered. The members of the committee were Eloise B. Sherman, M.D., Savannah, Chairman; Robert Wells, M.D., Atlanta, Vice-Chairman; Charles McDowell, M.D., Decatur; J. R. Turner, M.D., LaGrange; Donald Manning, M.D., Brunswick; Sammie Dixon, M.D., Tifton.

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D., Chairman

Your Constitution and Bylaws Committee has been quite busy this year with the 5-year review of MAG's Constitution and Bylaws. We forwarded a copy of the Constitution and Bylaws to legal council of the AMA, as they had stated they would be willing to review any state medical association's Constitution and Bylaws that might wish to avail themselves of this service. We also engaged two senior law students to review the Constitution and Bylaws and make a report to the committee, and our own legal council, Mr. Richard Vincent, has reviewed our Constitution and Bylaws.

After receiving and reviewing the reports from the attorneys and the students, your committee is of the opinion that major changes are needed in MAG's Constitution and Bylaws. Many of these changes are only "housekeeping," while others constitute major changes, some of which are needed so as to not be in conflict with the Federal Trade Commission and the U.S. Justice Department. In light of all this, your committee is of the opinion that MAG should have a short "stream-lined" Constitution so that it would not be necessary to amend the Constitution except on rare occasions. Your committee firmly believes that the Constitution of the MAG should be very short and concise, and as simple as possible. All enabling legislation and changes should be confined to the Bylaws. Your Constitution and Bylaws Committee, therefore, recommends the following Constitution for your consideration.

NOTE: This proposal must lie on the table for 1 year and may not be finally acted upon until the 1981 House of Delegates. **FURTHER NOTE** that your committee will recommend Bylaw changes to you during the 1981 House of Delegates, which would implement the new proposed constitution, and **FURTHER NOTE,** that this report does contain some "house-keeping" Bylaws, which we will introduce for your consideration, during this session of the MAG House of Delegates.

(In order to keep this report as short as possible, only the new proposed Constitution will appear in the body of this report; however, a copy of the old or present Constitution is attached to this report. Some new articles in the Constitution will be verbatim, as contained in the current Constitution.)

Article I – Name of the Association

The name of this Association is the Medical Association of Georgia. It is an Association of its component Medical Societies.

Article II – Objects of the Association

The objects of the Association are to promote the science and art of Medicine and the betterment of public health, as provided for in the Bylaws.

Article III – Component Societies

Component Societies which will form the Medical Association of Georgia are those county medical societies which hold charters from this Association or which may hereafter be organized and chartered as provided for in the Bylaws.

Article IV – Membership

Members. The members of the Association are members of the component medical societies. The Association is composed of active, service, associate, and honorary members, as provided for in the Bylaws. Other types of membership may be provided in the Bylaws.

Article V – House of Delegates

The legislative and policy making body of the Association is the House of Delegates, composed of elected representatives and others, as provided in the Bylaws. The House of Delegates shall transact all business of the Association, not otherwise specifically provided for in this Constitution and Bylaws, and shall elect the general officers, except as otherwise provided in the Bylaws.

Article VI – General Officers

The general officers of the Association shall be a President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, and ten (10) Directors. Their qualifications and terms of office shall be provided for in the Bylaws.

Article VII – Board of Directors

The Board of Directors is composed of seventeen (17) members: ten (10) directors, elected by the District Medical Societies, President, President-Elect, Immediate Past President of the Association, the Speaker and Vice-Speaker of the House of Delegates. It shall have charge of the property and financial affairs of the Association, and perform such duties as are prescribed by law governing Directors of Corporations, or as may be prescribed in the Bylaws.

Article VIII – District Societies

In order to promote the best interest of the profession, the House of Delegates shall provide for the division of the State into Director Districts, and the organization of all component county societies into Director District Medical Societies.

Article IX – Meetings

The House of Delegates will meet annually, and at such other times as deemed necessary, or as provided for in the Bylaws or by the Board of Directors.

Article X – Funds and Expenditures

Funds for the operation of the Association shall be raised by an equal per capita annual assessment on the members of each component society. The amount of the assessment shall be set by the House of Delegates upon recommendation of the Board of Directors. Funds may also be raised by voluntary contribution, from the Association's publication, dues, and in any other manner approved by the Board of Directors. The Board of Directors shall submit an annual budget to the House of Delegates and shall manage the finances of the Association.



Eloise Sherman, M.D., Savannah, reports to the House on Reference Committee A's recommendations regarding the Constitution and Bylaws.

Article XI – Official Publication

The official publication of the Association shall be the *Journal of the Medical Association of Georgia,* in which shall be published all official Association notices and abstracts of transactions of the House of Delegates.

Article XII – Seal

The Association shall have a common seal. The power to change or renew this seal shall rest with the House of Delegates.

Article XIII – Amendments

The House of Delegates may amend this Constitution at any session by a 2/3 vote of the Delegates present, provided that the proposed amendment shall have been introduced in the preceding session, and provided that the proposed amendment shall have been previously published in the *Journal* during the year.

Your Constitution and Bylaws Committee would recommend for your consideration several changes in the Bylaws during this session of the House of Delegates. These changes represent several "house-keeping" items, which your committee feels are necessary to clarify the Bylaws, and one amendment which would add a new committee to MAG's standing committees. This would be a Board of Past Presidents. The other amendment would be a change in student membership, resulting from a recommendation by this House, at its 1980 meeting. With these in mind, your Constitution and Bylaws Committee would recommend the following amendments to MAG Bylaws:

NOTE: Existing wording appears here as is. Suggested amendments by addition are indicated by underlining. Amendments for deletion are indicated by ~~striking through~~. It is possible to read the wording as it is suggested. Only those sentences preceding the suggested amendments are shown here.

ADDENDUM TO CONSTITUTION AND BYLAWS COMMITTEE REPORT

Your committee was asked by the MAG Board of Directors to clarify or amend the present Constitution and Bylaws as they pertain to the voting rights of Alternate Directors to the Board of Directors. Both the Constitution and the Bylaws must be amended in order to affect this change. Therefore, your committee offers the following language or amendment to the Constitution, Article VI — Board of Directors, Section 1. Composition "~~Alternate Directors shall be ex-officio members except in the absence of their respective Directors as provided for in the Bylaws.~~"

The new language would read: "Alternate Directors shall be ex-officio members without the right to vote except in the absence of the Director from their respective Districts. In the case of a District with multiple Directors, any Alternate from that District may vote in the absence of any Director from the same District."

RECOMMENDATION

Your Constitution & Bylaws Committee is of the opinion in reviewing the Constitution and Bylaws and in the interest of streamlining the organization that alternate directors are not necessary. Therefore, we would recommend that even though these amendments must lay on the table for a year, this amendment not be approved. We would recommend the approval of the proposed Constitution which makes no provision for alternate directors to the Board of Directors.

RECOMMENDATIONS (BYLAWS)

Chapter II — Membership — Section 8 — Student members: Your committee would amend this section by deleting the last sentence in this paragraph, which reads; "~~Student members shall not be required to pay membership dues, and shall enjoy the privileges of membership of the Association without the right to vote and hold office, and shall not be entitled to receive any publication of the Association except by personal subscription.~~" The new section would read as follows: Student members may be active members of the Association and may enjoy the same rights and privileges of all other active members and shall pay annual dues to the Association as fixed by the MAG Board of Directors.

We would amend Section 10 by deleting the last phrase, as follows: "A member suspended or expelled from membership in the Association shall no longer be a member of the Association and shall have none of its privileges during the period of suspension or after expulsion. ~~even though he may remain a member in good standing in a component medical society~~.

Chapter II — Section 13 — Jurisdiction: We would amend by the addition of two subsections to this section. Subsection (a), out of state members; if physicians reside and practice in other states, they may belong to county medical societies in Georgia, as long as they are members and in good standing of the state medical associations in their states of predominant practice. Such membership shall be applied for through the county medical society in Georgia with which they wish to affiliate and all business conducted through that county society and not the MAG. Subsection (b); if a member of the MAG temporarily moves to another state for continuing education, fellowship, additional residency, military service, or other reasons approved by their county medical societies, they may continue their membership in the MAG as long as they remain members in good standing (dues paying or dues exempt) in the county medical society in which they were members at the time they last practiced in Georgia.

Chapter IX — Funds and Expenditures — Section 2 — Dues and Assessments, Subsection 1: all active members of the Association who are also members of component county societies, other than those described in subsection 2, hereof, shall pay such dues and assessments in accordance with the following procedure: ~~Before October 1 of a particular year, the Secretary of a component county society shall certify to the Secretary of the Association, the names of members of the society~~ . . . The new amendment would read: The Secretary of each component society shall certify each year, on the date specified by the Secretary of the Association. . . . In Subsection 2 of Section 2; Dues and Assessments, we would amend this section as follows: The following procedure shall apply: The Secretary of such component county society shall cause to be collected and shall forward to the office of the Association ~~before January 1~~ the dues and assessments for its members. . . .

Chapter X — Committees — Section 1 — Standing Committees: We would amend Chapter X — Committees, Section 4 — Committee on Professional Conduct by deleting the final paragraph of the section which reads: ~~Any disciplinary action to a member by the Board of Directors shall only affect the member's standing in the Medical Association of Georgia. A written report of such disciplinary action shall be made to the Secretary of the component county medical society of which the disciplined member is a member, but such member's standing in his component county medical society shall not be affected thereby but only pursuant to action of the component county medical society according to its constitution and bylaws~~. And substituting in lieu thereof, the following: A written report of any disciplinary action against a member shall be made to the Secretary of the component medical society of which the disciplined physician is a member.

Your Committee has discussed many times the possibility of establishing a committee which would be composed of all living Past Presidents of the MAG. We feel that this would be a "blue ribbon" committee, composed of persons who have expertise in MAG's affairs. It is the feeling of the Constitution and Bylaws Committee that such a committee could be utilized in many aspects of the

Association. Therefore, we would recommend the following amendments to the Bylaws by addition.

We would amend Chapter X, Section 1 — Standing Committees by adding a new section (H) — Board of Past Presidents.

We would further amend Chapter X by adding a new section (9) — Board of Past Presidents: This committee shall be composed of all living Past Presidents. The Chairman shall be selected by the committee from among its membership. The Secretary shall be the Immediate Past President who shall be responsible for arranging the annual meeting of this committee. The Board of Past Presidents shall comprise a special Standing Committee whose duties will be to perform any charge given it by the House of Delegates or Board of Directors. The Board of Past Presidents may make any recommendation to the House of Delegates or Board of Directors which in its wisdom would benefit organized medicine and the MAG.

SUPPLEMENTAL REPORT OF THE CONSTITUTION AND BYLAWS COMMITTEE

John T. Mauldin, M.D., Chairman

At the 1979 annual meeting of the House of Delegates, you approved a recommendation from the AMA delegation report, Harrison L. Rogers Jr., M.D., Chairman, which stated that consideration be given by the MAG House to inclusion of a resident physician and a medical student as voting members of the House.

This recommendation was referred to the Constitution and Bylaws Committee and the Membership Committee of MAG. The joint meeting of these two committees were called, with only those of the Constitution and Bylaws Committee attending.

Your committee has spent some time dealing with the possibilities of establishing a residents business section and also the possibilities of a similar section for students. However, time has not permitted us to have a definite recommendation to this House at present.

Your committee will continue to work on this proposal during the coming year and will give a report before the 1981 House of Delegates.

ATTACHMENT TO THE CONSTITUTION AND BYLAWS REPORT

Attached here in the original annual report was a copy of current Constitution and Bylaws, which is not published in the *Journal* due to space constraints. A copy may be obtained from the Headquarters Office on request.

REFERENCE COMMITTEE DISCUSSION

The annual report of the Constitution and Bylaws Committee contains a proposed new Constitution for MAG. The committee obviously deliberated innumerable hours to compile such a document. The MAG Constitution requires that any proposed amendment to the Constitution must be introduced in the annual session preceding the session at which it is to be acted upon, and additionally published during the intervening year in the MAG *Journal*.

Your reference committee offered everyone who wished to be heard an opportunity to testify on the proposed Constitution, despite the fact that the document must lay on the table for 1 year.

Your reference committee also heard testimony on the proposed Bylaws changes and will make recommendations on each.

In the addendum to the Constitution and Bylaws Committee Report, an amendment is offered to the Constitution, Article VI — Board of Directors, Section 1. This amendment would clarify the voting privileges of Alternate Directors of the Board of Directors.

The first recommendation of the Constitution and Bylaws Committee on the Bylaws applies to Chapter II — Membership, Section 8, and would change the status of student members from nonvoting members to voting members and establish the mechanism for setting dues for them.

The second recommendation is a housekeeping amendment to Section 10 dealing with expelled or suspended members.

The third recommendation is an amendment that applies to Chapter II, Section 13 — Jurisdiction, and would add two subsections dealing with out-of-state members and members who move out-of-state. This is another housekeeping amendment.

The fourth amendment would amend Chapter IX — Funds and Expenditures, Section 2 — Dues and Assessments to allow the Secretary of MAG to set the date when the county society secretaries shall certify to MAG the names of their respective societies' members. It also changes the January 1 date for submission of dues. Your reference committee wishes to point out that there is one additional October 1 date that will also need to be struck. It appears in the same Section 2 in paragraph 2.

Your reference committee later in this report will offer amendments to Subsection 2 of Section 2 under Chapter IX — Funds and Expenditures, to bring that section in line with the proposed amendments offered by the Constitution and Bylaws Committee.

The fifth amendment would amend Chapter X — Committees, Section 1 — Standing Committees, Subsection 4 — Committee on Professional Conduct. This is another housekeeping amendment and is in keeping with unified membership.

The sixth amendment offered by the Constitution and Bylaws Committee would amend Chapter X, Section 1 — Standing Committees, by adding a new section (H) — Board of Past Presidents.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that the proposed Constitution be not adopted.

Mr. Speaker, your reference committee respectfully requests that since each amendment to the Bylaws must lay on the table for one day, each of our recommendations should be heard today but that final action be postponed until tomorrow.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee would recommend that the first amendment to the Bylaws offered by the Constitution and Bylaws Committee concerning Chapter II — Membership, Section 8 — Student Members be not adopted.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends adoption of the second proposed amendment of the Constitution and Bylaws Committee dealing with Bylaws, Section 10.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee advises adoption of the recommendation by the Constitution and Bylaws Committee regarding Bylaws, Chapter II, Section 13 — Jurisdiction.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee advises adoption of the recommendation on Bylaws, Chapter IX — Funds and Expenditures, Section 2 — Dues and Assessments, Subsection 1, and further recommends that Subsection 2 be amended by deletion of "~~before October 1st of a particular year with respect to the coming calendar year~~," and by deletion of "~~before January 1st~~. . . . "

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee advises adoption of the recommendation of the Constitution and Bylaws Committee regarding Bylaws, Chapter X, Section 4 — Committee on Professional Conduct.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that the recommendation of the committee on Chapter X, Section 1 — Standing Committees by addition of a Board of Past Presidents be not adopted.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee wishes to recommend approval of the new language concerning alternate directors as presented in the addendum to the Constitution and Bylaws Report. This would amend the Bylaws, Chapter V — Board of Directors, Section 8, by deleting the last sentence reading, "~~He becomes a voting member of the Board of Directors only in the absence of the Director from his district~~," and substitute new language as follows: Alternate Directors shall be ex-officio members without the right to vote except in the absence of the Director from their respective districts. In the case of a district with multiple Directors, any Alternate from that district may vote in the absence of any Director from the same district."

HOUSE OF DELEGATES ACTION

The House voted to not adopt the proposed Constitution, the first proposed amendment in the Bylaws on full privileges for student members, (Chapter II, Section 8) and the sixth amendment regarding a Board of Past Presidents (Chapter X, Section 1, Subsection 4). The House approved the second amendment to the Bylaws dealing with expelled or suspended members (Section 10); the third amendment regarding Bylaws, Chapter II, Section 13 — Jurisdiction; the fourth Bylaws amendment, Chapter IX — Funds and Expenditures, Section 2 — Dues and Assessments, and further approved amending Subsection 2 to bring it in line with the first section: the fifth amendment, Chapter X — Committees, Section 1 — Standing Committees, Subsection 4 — Committee on Professional Conduct; and further approved amending the Bylaws, Chapter V — Board of Directors, Section 8, as recommended by the Reference Committee.

REPORT OF THE PRESIDENT

Earnest C. Atkins, M.D.

Thank you for electing me President of the Medical Association of Georgia, the finest medical group in the world. It has been an honor and a pleasure to serve you, and I have especially enjoyed visiting your local medical societies and working with you on a one-on-one basis.

We have the finest staff in the history of MAG. They have served you well, and in the future we can and should expect an even greater performance.

We started the year in May by getting back to the fundamentals — better patient care — and recommended the Golden Rule to you. In June, we put a rudder on the S.S. MAG with a 2-day session on goal setting and assigning priorities.

On June 23 and 24, 1979, the Executive Committee and MAG staff met at the Perimeter Marriott Hotel in Atlanta to discuss and define what the purposes, goals, and priorities of the MAG should be. We met from 9:00 a.m. to 7:00 p.m. on Saturday and from 8:00 a.m. to noon on Sunday. I heartily commend all those who participated in this important meeting.

The discussions were candid and unrestrained. The following is my interpretation of what transpired.

I. A lengthy presentation by executive staff members of individual functions was first. This was mailed to all board members and is available to all members. Our MAG staff deserves a pat on the back for the multiplicity and complexity of the many tasks they perform so well.

II. We could not change, or even suggest, improvements on the purposes of the Association stated in the Constitution and Bylaws as revised by the House of Delegates at the 1977 Annual Session, April 24, 1977. (The President's Report included a copy of MAG's Bylaws as they were written at the time of his report.)

III. Our goals were discussed and agreed upon from many prospective angles; here they are from my vantage point.

A. MEMBERSHIP SERVICES — This is clearly stated in the Bylaws (Section 1).

1. *Recruitment of New Members*

a. *MAG* — We have over 4,700 of the 6,300 physicians in Georgia eligible for membership. This year I would like to see us increase our count by 10% (470), but this year let's go for quality. Help me make MAG so vital to medicine in our state that it will really enhance your status to be a member. To accomplish this we may also have to do a little weeding.
b. *AMA* — My goal for AMA membership is to have enough this year for us to have a fifth AMA delegate. If half the MAG non-AMA members joined, this would be accomplished. We failed to accomplish this goal, but we will do it yet.
c. *Residents* — These are the young doctors of tomorrow who will take our places in organized medicine. To interest them, we should offer them a voice and a vote. We can capitalize on the experience of AMA's residents and interns business section or even have a component society for them comparable to our component county societies.
See Recommendation #1.
d. *Interns* — These doctors will take our place day after tomorrow. It is impossible to overemphasize the value of these young minds with new ideas. We should get them into the fold early.
e. *Students* — To interest students in organized medicine we must first get the support of their teachers. Think about a chair of private practice in each of our three medical schools. I recommend them, and MAG can easily support them.
See Recommendation #2.

2. *Information*
a. *Newsletter* — This gives current news monthly and, with thanks for the support by Roche Laboratories, we plan to continue.
b. *MAG Journal* — Read this issue from cover to cover and you will join me in thanking our editor, staff and contributors for this prize-winning publication.
c. *Telephone Calls* — A vital area of rapid communication where we can be of service to our members, no matter how time-consuming to our staff and officers. Call us: 404-876-7535. WATS LINE: (800) 282-0224.
d. *Research* — We have a mint of information that we are eager to pass on.
e. *Special Mailing* — Up-to-the-minute information that is invaluable and justifies the high cost.

3. *Education* — To me, this is it! To continue better patient care, we must first *learn* and then *advance* the art and science of medicine.
a. *Accreditation of Hospital Continuing Medical Education* — We have come a long way in this area and are planning some giant steps for the future.
b. *Scientific Assembly* — This is our big opportunity to coordinate and promote the scientific programs for our specialty societies. It was a winner.
c. *Other Meetings Sponsored by MAG* — You name it and, if it benefits us, the members and our patients, we'll do it. To name a few: PEP Seminar, Health Planning Conference, Cost Awareness Conference, Pre-Practice Seminar, etc.

4. *Lobbying — State and Federal* — We are highly successful here because we are *not* self-serving but are fighting for our patients. Also, because of our excellent Legislative Committee and staff along with your hard work, we have laid the foundation through candidate support with GaMPAC funds. To continue this success story, you must give your money and your time.

5. *General* — This list could go on forever.
a. *Insurance* — Each year our professional liability insurance committee negotiates enough savings on the premiums to pay our MAG dues. The membership insurance committee is working hard to improve our other programs; such as, office overhead, disability, life insurance, etc.
b. *Print Shop* — A real convenience to our office headquarters plus quality work at a savings to you. Inquire — you'll be glad. This is a financial failure.
See Recommendation #3.
c. *Specialty Society Service* — This is a challenge we must meet for continued *unity*.
d. *Disabled Doctors Program* — Doctors Helping Doctors — Ask any member of the program about MAG's new medical school.
See Recommendation #4.

B. *Community Services*
1. *Access to Care* — Our Bylaws (Section d) say it all. My goal is to increase the number of physicians in underserved areas by 10% per year. To help do this, we should and can use existing clinics and programs.
2. *Quality of Care* — Our patients deserve the best.
a. *Discipline* — We must maintain the highest standards of professional conduct and adhere to the principles of medical ethics. We must tighten our belts locally as well as statewide and continue our efforts to aid the Composite Board of Medical Examiners.
b. *Peer Review* — We must make this work for better patient care as well as protecting our peers.

c. *Continuing Medical Education* — Once we educate ourselves, then we can educate our patients on a continuing basis. In addition to practicing good crisis medicine, I would like to see us promote good preventive health measures to all. This can best be done through the educational process.

3. *Information*
 a. *MAG Positions* — A quick reference guide was compiled by an MAG Past-President. This is very helpful and will be continued and expanded. Also, cue cards are being developed on current issues and positions. These will be well-utilized to promote a positive approach for our positions.
 b. *Telephone Calls* — Time-consuming but personal, effective handling can put an irate caller on our team.
 c. *Letters to the Papers, Etc.* — In addition to answering editorials, I am trying to arrange personal interviews to the editors to volunteer source material and our help. You should write, too, but always in the interest of our patients.
4. *Education* — To be a good teacher, first we must be a good student.
 a. *Public* — After we have learned our lessons well, then and only then should we take on the task of educating our patients — first of all, "be prepared."
 b. *Schools* — We must lead the way for good health practices to be taught in the early grades.
 c. *Patient Education* — As I have said before, we can always win on our own home field — our office and hospitals — if we will follow the Golden Rule. The best patient education is one-on-one. We will develop pamphlets and materials to help, but remember — eyeball to eyeball.
5. *Cost Containment* — Our Cost Awareness Committee is doing an outstanding job. The Cost Awareness Seminar was held at the Peachtree Plaza Hotel on August 25, 1979. The seminar was excellent, though attendance poor. This is our usual story.

C. *Liaison*
1. *Specialty Societies* — there we are. To promote our mutual goals, we need to be under the big tent together. Splintering will destroy us — unity will continue to make our great country number one in health care.
2. *Health-Related Organizations and Groups* — Here we need to face reality and discard the impossible. We must accentuate the positive and work with these groups for the benefit of our patients. I believe the pendulum is swinging in that direction.
3. *Government* — Now comes the real world. The HSA Task Forces were discussed at the Health Planning Conference in May 1979 and are now underway by this active committee. We suffered a real blow by the recent death of this loyal MAG committee chairman, but I am happy to report to you that the show must and is going on.

D. *Professional and Public Relations* — This fine committee with its outstanding chairman has a very ambitious program. As individuals, we must conduct our own doctor-patient relationship in such a manner that this committee will have something *positive* to relate and not have to explain our own poor image.

E. *Legislation* — Another blue ribbon committee with a seasoned veteran for its chairman . . . can continue to spell success if we will give them our support.

IV. *Priorities*

A. *Legislation and Government Affairs* — We have outstanding committee chairmen, staff and committee members. They need our help — all 4,700 of us. Our record is good, but we can make it better.

B. *Positive Public Relations* — We have an excellent program, chairman, staff and committee. Be positive, and win with each patient-doctor relationship and this program will present your fine work well.

C. *Education-Public Education* — This committee is big and has a great chairman, staff, subcommittee chairman, and members. This committee has come a long way during my time at MAG. If we will reinforce recognition of an ongoing, lifelong need for continuing medical education in the art and science of medicine, we can go to the moon.

D. *Membership*
 1. *Quantity* — I know we can attain this goal.
 2. *Quality* — This is not only a goal we should strive for but an obligation we must meet for our patients.

E. *Staff Reorganization* — MAG has the finest staff in its 130 years of existence, and I am proud of every member. We began staff reorganization for utilization, efficiency and better service to our members and patients, and I am pleased with the results. I am looking forward to more progress. The Hay Report has been very valuable in this endeavor.

F. *MAG Headquarters Building* — We are bursting at the seams and are studying expansion for better utilization of space, efficiency and better utilization of space, efficiency and better service to you.
See Recommendation #5.

In July, I recommended education and not regulation to improve our patient's health without increasing the health care cost. I also pointed out the confidence our patients have in us and hope we will continue to justify this confidence.

The August "President's Letter" pointed out how to be a winner in keeping with our number one priority, legislation and government affairs. So far, we haven't done too well, but it's never too late to become a winner.

In September, I dared you to let our patients set fees with which they would be happy. Most of you are doing this anyway.

Later, I gave you two good reasons to fight government intervention in medicine instead of joining. They are: the cost of medical care will increase, and the quality of medical care will decrease.

In November I predicted the "Fall of the House of Medicine." With this dire prediction, I also pointed out how to prevent it — unity.

The AMA is being attacked by many of us; however, there is more than one way to skin the AMA cat — join it.

I tried to set the record straight in January by giving figures to show that physicians aren't the cause of inflation and the high cost of medical care, but that government itself is the cause.

We are all working toward a common MAG goal, but I pointed out how too many cooks can spoil the broth.

In March, I gave away the secret of the location of MAG's Holy Grail. This precious treasure is our ability to give excellent patient care, and we find it in our own office.

As I end my year as your President, again I promise you that I will not seek any elected office of the MAG but will continue to give you my full support. I have a dream, and I will share it with you. I dreamed that we doctors began caring so much about and for our patients that excellent medical care was available to all Georgians at a reasonable cost.

PRESIDENT'S RECOMMENDATIONS

1. A residents medical society be organized with equal rights for membership, representation on the Board of Directors and House of Delegates, and voting privileges the same as a member of a county medical society. This will get our young members interested, active, and participating at an earlier age.
2. Organize and support a chair of private practice in each of our three medical schools.
3. The print shop has been a financial disaster. Neither the majority of our MAG members nor the staff is interested in supporting it. Direct the MAG Services, Inc., Board of Directors to dispose of it in a manner that will be most beneficial to MAG.
4. The Disabled Doctors Program is the MAG program of which I am most proud. I recommend that the House of Delegates commend the Disabled Doctors committee, staff, and all others involved for their success and for the favorable status MAG has attained from the other 50 medical associations.
5. Recommend no dues increase until our liquid assets, including the land acquisition fund, are below $500,000, and allow the spending of these reserves to be done with the recommendation of the Finance Committee and the approval of the Board of Directors.
6. Recommend the Georgia State Medical Society and especially its President, Dr. Nelson McGhee, be commended for its outstanding liaison program with MAG.

REFERENCE COMMITTEE DISCUSSION

The report of the President emphasizes his perception of the goals of the Association developed by a special meeting of the Executive Committee in June, 1979. Dr. Atkins is to be highly commended along with a number of others for establishing goals and priorities for the Association. Your Reference Committee would note that the Chairman of the Board, Dr. Joe Stubbs, also addresses the subject of goals and priorities.

The report is also testimony of the President's personal goal of returning to the fundamentals of better patient care. The report contains six recommendations, but this Reference Committee has been referred only items 1, 2, 4, and 6. Recommendations 3 and 5 have been referred to Reference Committee F.

Recommendation 1 would create a residents' medical society, with privileges for its members similar to any county medical society.

Recommendation 2 requests the organization and support of a chair of private practice in each of the three existing medical schools.

Recommendation 4 commends MAG's Disabled Doctors' Program.

Recommendation 6 commends the Georgia State Medical Association and especially its president, Dr. Nelson McGhee, for his liaison work with MAG.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, on Recommendation 1, your reference committee wishes to advise the House that a similar recommendation appears in the Report of the AMA Delegation (Director 17 Report). The AMA Delegation Report of 1979 also made a similar recommendation. Mr. Speaker, your reference committee also would call to the House's attention the Supplemental Report of the Constitution and Bylaws Committee (Committee Report 6-A) in which the Committee reports it will continue to work on this proposal and will give a report before the 1981 House of Delegates. Mr. Speaker, your Reference Committee wishes that Recommendation 1 of the President's report and Recommendation 1 of the AMA Delegation report be considered together. Your Reference Committee has previously recommended that the Bylaws amendment on student members be not adopted.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that the MAG Membership Committee initiate a renewed campaign to recruit student and resident members as they may hold the future of our Association but that granting full voting privileges to students is not the answer to gaining additional members in the MAG.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that Recommendation 1 of the report of the

RESOLUTION 25
OUT-PATIENT INSURANCE

WHEREAS, being able to perform professional medical services on an out-patient basis that were formerly performed on an in-patient basis will provide a cost savings to both the patient and their third party carriers, and

WHEREAS, physicians should be reimbursed for professional medical services rendered by the charging of a professional fee, and

WHEREAS, the physician should also be reimbursed for technical overhead expenses incurred performing the professional medical service — the combined charge being a professional charge, be it,

RESOLVED, that the MAG fully endorses the above concept in the in-patient — out-patient insurance bill recently passed in the state legislature, be it further

RESOLVED, that whatever professional medical services are to be rendered on an out-patient basis be at the discretion of the patient and the attending physician.

REFERENCE COMMITTEE DISCUSSION

This resolution asks that the MAG fully endorse the reimbursement of physicians for out-patient services as well as in-patient services as covered in the insurance bill recently passed by the Georgia legislature. It further calls upon the MAG to take the position that whatever professional medical services are to be rendered on an out-patient basis be at the discretion of the patient and the attending physician.

Testimony summarized the recently passed bill as defining the insurance commissioner's prerogative to consult with MAG as to which procedures are suitable for outpatient service and third party payment. This would apply to new contracts only and for individual coverage, not groups. The bill further provides that the mechanism for quality assurance be set up.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that for the purpose of clarity the first RESOLVED be amended as follows:

"RESOLVED, that MAG fully endorses the concept that the physician should be reimbursed for out-patient services as well as in-patient services as covered in the insurance bill recently passed in the state legislature."

Mr. Speaker, your Reference Committee recommends adoption of Resolution 25 as amended.

HOUSE OF DELEGATES ACTION

Adopted Resolution 25 as amended by the Reference Committee.

Mr. Speaker, this concludes the report of Reference Committee D. Your Reference Committee would like to thank all those who participated in our discussions and deliberations. The members of the committee were: Spencer S. Brewer, Jr., Atlanta, Chairman; J. Moultrie Lee, Savannah, Vice-Chairman; H. E. Weems, Jr., Perry; Charles A. Lanford, Macon; Bradwell R. McAlister, Gainesville; and McAlpin H. Arnold, Elberton.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial-Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANNASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

TALK IS CHEAP

in the *Journal*'s Classifieds

Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The *Journal*'s **Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.



Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.





Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reoorted with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8—5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10—20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-0015-1

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001 5-80 Printed in U.S.A

NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

First Class Permit No. 1563, Shreveport, LA.

Postage will be paid by addressee

BOOTS PHARMACEUTICALS, INC.

Department 0
6540 Line Avenue
Shreveport, LA. 71106

BOOTS PHARMACEUTICALS INC.

Shreveport, Louisiana 71106

Pioneers in medicine for the fami

President and Recommendation 1 of the report of the AMA Delegation be not adopted.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee strongly supports the concept in Recommendation 2 of the report of the President. Your reference committee recommends that Recommendation 2 be referred to MAG's Education Committee and that the Education Committee make specific recommendations to the Board of Directors concerning this item.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee advises adoption of Recommendation 4.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee advises adoption of Recommendation 6.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee asks that the record of these proceedings reflect the tremendous gratitude that is due Dr. Atkins for his untiring dedication to his patients and to organized medicine.

HOUSE OF DELEGATES ACTION

The House directed that the MAG membership committee initiate a renewed campaign to recruit student and resident members. The House rejected Recommendation 1 of the President's report and Recommendation 1 of the AMA Delegation's report. The House referred Recommendation 2 of the President's report to the Education Committee and directed the Education Committee to make specific recommendations to the Board of Directors. The House approved recommendations 4 and 6 of the President's report, and commended Dr. Atkins for his accomplishnents.

REPORT OF THE SPEAKER OF THE HOUSE

L. C. Buchanan, M.D.

The Speaker of the MAG House of Delegates has major responsibilities in planning and conducting the convened meeting of the House each year during the MAG Annual Session and of any special meeting of the House called in accordance with Bylaws provision. In discharging these responsibilities and coordinating the conventions of the House of Delegates with other activities of the Annual Session, the Speaker is assisted by the Annual Sessions Committee consisting of the incumbent Association President, the President-Elect, the Vice Speaker, and the Speaker of the House. The Speaker also serves as a voting member of the Association's Board of Directors and of its Executive Committee, and in these capacities I perceive it to be his duty to point out any action contemplated by these bodies when such action is in conflict with previous actions or direction declared by the House of Delegates.

The annual report of an officer is not properly used to either display personal endeavors seeking acclaim, nor as a vantage mechanism for criticizing individuals, groups, or policies not in accord with the philosophies of the reporter. More appropriately, such a report should present an accurate account of pertinent activities of the office since the most recent preceding report, as well as a declaration of the current state of the office.

During the 8 years ending with this 1980 Annual Session, as Vice Speaker in 1973 and 1974, and as Speaker from 1975 to the present, I have attempted to discharge these formal responsibilities to the best of my ability and respectfully leave assessment of performance to the judgement of the membership. The activities of the office of Speaker as regards the House convened are comprehensively reported in the annals of the 1979 Annual Session as reported in the July 1979 "Proceedings" issue of the *Journal. In res loquitaur.*

In reporting on the state of the office, it appears to me that 8 years continuous exposure to the innermost workings of the Association inevitably results in certain observations and conclusions which should be shared by anyone who sincerely desires that MAG attain permanence and exert its proper continuing influence for the good of the patients and physicians of Georgia. Such a desire is the sole motivation for submitting the following personal observations and conclusions as well as the summation recommendation:

I. **Purpose** — The purpose and goals of MAG as presently stated are overly simplistic and require reevaluation, deliberate study, and consideration of redefinition.

II. **Constitution and Bylaws** — For too long the Constitution and Bylaws have been amended, changed, and compromised in piecemeal fashion. In 1979, the AMA legal department cited numerous minor and major deficiencies, some of which are allegedly in conflict with federal statutes and possibly place the MAG in a vulnerable position for litigation. The Constitution and Bylaws require deliberate, mature study, legal consultation, and overall reconstruction. The Constitution might well be contracted and the more easily amended Bylaws expanded. Some of the needed changes will restructure the organization of the Association, and this project will admittedly be a tedious and time consuming but vital undertaking, dictating careful selection of individuals charged with the task. This group should include some relatively newer MAG members.

III. **Staff** — The loyalty and dedication of the headquarters staff is beyond question; however, the efficiency, delegation of responsibilities, and internal organization of the many activities of the Association, the economy of operations, the long-term provision for personnel stability and satisfaction, etc., continue to need objective, professional analysis and planning instead of the crisis to crisis management of the past. This unpopular challenge continues to be procrastinated to the detriment of the Association.

IV. **Legislative Activity** — For years, the MAG has enjoyed a rapport with state government agencies and the Georgia executive and legislative branches, second to none in the nation. This has been primari-



MAG delegates listen to testimony during Reference Committee A hearings and include L-R: Drs. Joe L. Nettles, Savannah; Harrison L. Rogers, Jr., Atlanta; H. Hilt Hammett, Jr., LaGrange; and Frank W. McKinnon, Marietta.

ly due to the efforts of two true professionals, Dr. James A. Kaufmann and Mr. Rusty Kidd. It is a disturbing but inescapable fact that future generations of MAG cannot always expect to be as fortunately represented. Immediate provision for dedicated apprentice understudies to attempt to prepare for future strength in this important area is imperative and long overdue. Years of such "on-the-job" training will be required to provide continuing effective capability for MAG in this field.

V. **Board of Directors** — This observation has been repeatedly debated in the past, but the Board of Directors as presently structured is too large and makes for inefficiency. It must meet at shorter intervals or be content for many important matters to be handled and major policy decisions made by the six or seven member Executive Committee, a policy which has caused some dissention in the past. This matter will also be involved in any reevaluation of the Constitution and Bylaws.

VI. **Discipline** — Matters of ethics, professional and personal conduct, discipline, etc., are presently assigned to a standing committee on Professional Conduct appointed by the Executive Committee with final adjudication and disposition being the responsibility of the Board of Directors, "Which shall also serve as a Board of Censors." An elaborate procedural protocol for committee action is properly provided in the Bylaws. This lack of separation of executive and judicial powers has been questioned in the past, is considered a serious liability by AMA legal experts, and needs prompt reassessment. Creation of a separate Judicial Council for jurisdiction in such matters needs to be seriously considered again.

VII. **Ethics** — It has been repeatedly demonstrated that our profession consistently maintains top position in public opinion as regards respect, trust, honor, and reliability, although quantitatively this image has progressively been eroded during recent years. In these times of increasing permissiveness, laxity, and attenuation of moral values, it is my personal judgement that the medical profession should set the pace of proper ethical standards. Furthermore, the prescription of standards by which all may judge a physician's conduct "in his relationship with patients, colleagues, members of allied professions, and the public" must be the prerogative of our profession, and we must never accept ethical standards promulgated by any other source. To this end, it appears most appropriate for the MAG to carefully develop and proudly display a Code of Ethics irrespective of what other groups, including the AMA, may choose to do in this arena. Hopefully, such an instrument would be compatible with that of the AMA and possibly be even more specific if indicated.

Once such a code has been endorsed by the MAG House of Delegates, signed subscription to it should be pledged and renewed annually as a required condition to MAG membership. Under such requirement, if an MAG member acts in a manner to discredit the entire profession, it would enhance the image of the profession and of our Association to cite his violation of the Ethical Code to which the remainder of us adhere.

These observations and conclusions are admittedly too comprehensive to be addressed for immediate implementation by this current session of the House of Delegates; however, the urgency for immediate action to begin important changes so long overdue would seem clearly apparent.

If the 1980 House of Delegates perceives that any or all of these propositions are desirable, affirmative action on the following recommendation would make your retiring Speaker feel that some of the time and effort expended over the last several years was indeed worthwhile.

SPEAKER'S RECOMMENDATION

That the 1980 House of Delegates create an *ad hoc* committee of the House empowered to implement at the earliest possible time those of the foregoing suggestions and changes which the House desires. Such propositions will for the most part require 1-2 years for implementation in accordance with current Constitution and Bylaws provisions but most could be effected, if strategically planned, by the 1981 House of Delegates.

Such a committee should be small in size, with members who are knowledgeable regarding MAG activities, constrained only by the Constitution and Bylaws, and responsible to the House of Delegates. The retiring Speaker does not wish to serve as a member of the proposed committee but is willing to assist the committee if requested.

FISCAL NOTE: Necessary costs of additional legal services probably not in excess of $1,000-$1,500 above current legal fees. If in-depth professional management analysis is employed, a negotiated fee for service of $8,000-$10,000 would be required.

REFERENCE COMMITTEE DISCUSSION

The Speaker of the House, Dr. L. C. Buchanan, outlines in his report several conclusions and observations for the consideration of this House of Delegates.

Your reference committee wishes that the record of these proceedings reflect a commendation to Dr. Buchanan for his outstanding service to the Association as Speaker from 1974 to 1980 and as Vice Speaker from 1973 and 1974.

The report is also testimony of the Speaker's dedication to his Association and to his untiring efforts to make the MAG the finest state medical association in the nation.

The Speaker's Recommendation is that the House create an *ad hoc* committee of the House to implement at the earliest possible time the conclusions set forth in his report. He includes a fiscal note to total between $900 and $11,500 for implementation.

The first observation of the Speaker is that the purposes and goals of MAG are overly simplistic and require reevaluation, study, and consideration of redefining. The Chairman of the Board's first recommendation also speaks to goals.

The second observation is that MAG's Constitution and Bylaws require deliberate, mature study, legal consultation, and overall reconstruction. The Speaker points out that the AMA's legal staff cites numerous deficiencies, some of which are in conflict with current federal statutes.

The third observation deals with staff. The Speaker observes that staff organization continues to sorely need objective, professional analysis, and improved planning. The possible advantages of seeking professional outside management assessment was suggested to help solve this problem.

The Speaker's fourth observation is that the MAG needs an apprentice mechanism in the area of legislation to prepare the MAG staff for a future time when those currently responsible for MAG's legislative successes may not be available.

The Speaker's fifth observation is that the current Board of Directors is too large which makes for inefficiency. The Constitution and Bylaws Committee also addresses this same issue.

The Speaker's sixth observation concerns discipline and asks that a separate Judicial Council be created, as there is currently a lack of separation between MAG's executive and judicial powers. Your reference committee wishes to point out that a similar recommendation was made by the Committee on Professional Conduct and Medical Ethics and was not adopted by the 1979 House of Delegates.

The Speaker's seventh observation concerns ethics. The Speaker asked that MAG thoughtfully develop and proudly display a Code of Ethics which, once approved by the House of Delegates, shall be pledged and reviewed annually as a requisite for MAG membership.

REFERENCE COMMITTEE RECOMMENDATIONS

Mr. Speaker, after considerable deliberation, testimony, and consideration of ongoing problems as listed in the report of the Speaker, items 1 through 7, as well as Recommendation 1 of the Chairman of the Board, your reference committee recommends the organization of an aggressive committee to immediately address these problems. We further recommend this committee be appointed by Drs. L. C. Buchanan, Joe C. Stubbs, and H. Hilt Hammett Jr. It will consist of 7 or 9 dedicated members. While utilizing experience, a majority of the committee will not be members of the Board of Directors. This committee should proceed without delay to evaluate these goals. The committee is further directed to make recommendations to the Board of Directors concerning implementation of its actions, and to report its accomplishment to the 1981 House of Delegates.

Reference Committee Chairman Eloise Sherman asked that an editorial change be made to make the last two sentences of the Reference Committee report read: ". . . should proceed without delay to evaluate, and where indicated implement these goals, and to report its accomplishment to the 1981 House of Delegates."

Delegate F. William Dowda, of Atlanta, moved to amend the Reference Committee's report to the original wording of its recommendation.

HOUSE OF DELEGATES ACTION

The House approved the Reference Committee's recommendation as amended by changing the last 6 lines in the Reference Committee's Recommendation to read: This committee should proceed without delay to evaluate these goals. The committee is further directed to make recommendations to the Board of Directors concerning implementation of its actions and to report its accomplishment to the 1981 House of Delegates.

REPORT OF THE OFFICE OF THE CHAIRMAN OF THE BOARD OF DIRECTORS

Joe C. Stubbs, M.D.

The 1979 House of Delegates approved my recommendation in last year's annual report " . . . that the Board of Directors should be requested to develop a process through which it would identify goals and objectives of the Association and to establish priorities for the long range and the short term. The Board should report to the House on its activities and progress in this endeavor."

Since members of the MAG Executive Committee are elected by the House of Delegates (with the exception of the Chairman of the Board who is elected by the Board of Directors) and is therefore a representative voice for the House, the Executive Committee appeared to be the best group to determine goals and objectives of the Association. Accordingly, at the June 1979 meeting, the MAG Executive Committee, under the leadership of President Earnest C. Atkins, M.D., was appointed to implement the above directive of the House.

A special-called meeting of the Executive Committee to set goals was held June 23-24, 1979, in Atlanta, to which members of the MAG executive staff were invited. I have asked Dr. Atkins to report to the House in detail on progress made through the year towards implementing

goals and objectives (see the report of the President). Briefly stated below are the goals recommended by the Executive Committee and approved by the Board of Directors at its September 1979 meeting:

GOALS AND OBJECTIVES:

I. *Membership Services:*
 A. *Recruitment of new members* for MAG and AMA, with emphasis on students, interns, and residents.
 B. *Dissemination of information via: Newsletter, JMAG,* phone calls, research, and special mailings.
 C. *Education:*
 1. Accreditation of hospitals with continuing medical education.
 2. Scientific Assembly
 3. Other MAG-sponsored meetings
 D. *Lobbying:* State and Federal
 E. *General Items,* such as:
 1. Insurance
 2. Printshop
 3. Special society services
 4. Disabled Doctors Program
II. *Community Services:*
 A. *Access to care*
 B. *Quality of care:*
 1. Discipline
 2. Peer Review
 3. Continuing medical education
 C. *Information:*
 1. MAG positions on key health issues
 2. Phone calls
 3. Letters to newspaper editors, etc.
 D. *Education:*
 1. Of the public
 2. In schools
 3. Of patients
 E. *Cost containment*
III. *Liaison:*
 A. Specialty society services
 B. Health-related organizations and groups
 C. Government agencies
IV. *Professional and Public Relations*
V. *Legislation*

The following assignment of priorities was recommended by the Executive Committee and approved by the Board:

PRIORITIES ASSIGNED TO GOALS:

I. Legislation and government affairs
II. Positive public relations
III. Public education
IV. Membership:
 A. Quantity
 B. Quality
V. Staff reorganization
VI. MAG Headquarters building

In considering the process by which goals and objectives are to be set, the Board should consider obtaining the assistance of outside organizational consultants experienced in leading groups such as ours through exercises specifically designed to establish goals and priorities that accurately and completely reflect the views of the Association. Specialists in this field have developed programs that concentrate on an Association's goal-setting process where the end result is the development of an accountability system that can both monitor and measure progress made toward the accomplishment of goals previously set.

More specifically, such structured exercises enable the group (Board of Directors, Executive Committee, or special committee, etc.), including the staff, to identify and establish priority areas of concentration for the work of the Association, and, most importantly, to set measurable performance objectives. It is vitally important to have a system that can measure the accomplishment of Association goals and objectives. For the system to be effective, however, we must be able to establish realistic, obtainable goals when set in the context of our total work commitment. It is my firm belief that to do this properly we should call upon outside consultants experienced in this field.

In summary, we could anticipate:

(A) Goals that accurately reflect the wishes of the membership;
(B) Realistic setting of priorities from among the agreed-to goals;
(C) Measurable progress towards the accomplishment of our goals; and
(D) Greater understanding and agreement on goals and objectives by all parties concerned.

As my third term of service as Chairman of the Board comes to a conclusion, it leaves me with mixed emotions. I have a deep sense of satisfaction over the accomplishments achieved by your Board of Directors. These loyal and devoted members (36 Directors and Alternate Directors representing all geographical areas of the state) have been faithful in attendance of the quarterly Board meetings, not to mention hours given to work of the Association between meetings. I wish to extend my personal thanks to the members of the Board and ask the House to join me in the highest commendation for the efforts of your Directors and Alternates.

Although the membership is generally informed of important Board actions via the MAG *Newsletter,* I would like to mention one innovative step that has been taken to keep the Board of Directors more fully informed. Interim actions taken by the Executive Committee at its monthly meetings are now presented to the Board of Directors at each quarterly meeting for ratification by the Board. This process not only serves to keep Board members more fully informed but gives the Board a voice on interim actions.

In addition, the Headquarters executive staff has provided a new informational service to the Board members by compiling, printing, and distributing "cue cards" to members of the Board. These cards, broken down by subject, succinctly state MAG's position on a variety of issues. They enable Board members to have at hand an accurate and current statement of MAG's views and positions when inquiries are made of us by local newspapers or

radio and television stations. Staff is to be highly commended for its efforts in this regard, as is President-Elect H. Hilt Hammett Jr., who initially requested the project.

My last year as Chairman of the Board was not entirely free of some disappointment. I seem to have fought a losing battle in my conviction that the Headquarters staff is spread too thin and needs increasing; further, that the current space provided for the Headquarters staff is far too cramped and inadequate. If the staff is increased at any level, executive or secretarial, there is no space in the present set-up to permit even an additional desk.

At the September 1979 Board meeting, the President was charged to appoint a new Building Committee with direction to bring a positive proposal to the Board in January. Accordingly, at the January Board meeting, H. Duane Blair, M.D., Chairman of the *Ad Hoc* Committee on Building and Land, reported the following recommendation by his committee: (1) that MAG stay at the present Headquarters building, and (2) that MAG re-evaluate which way to go to expand or make improvements at the present location. The Board of Directors accepted the committee's report for information and directed that it be included in the Chairman of the Board's report to the next meeting of the House of Delegates.

In closing, I would like to again express my appreciation to the members of the Board for their cooperation and support. I would also like to thank each member of the Headquarters staff who enabled us to carry out the directives of the House and the purposes of this Association. As soon as the Proceedings of the 1979 House of Delegates were printed, the executive staff prepared recommendations on how to implement actions taken by the House. Staff's recommendations were approved by the Board at its June 1979 meeting, and House actions were then implemented. A copy of the 1979 actions is included in your 1980 Handbook for your information.

BOARD CHAIRMAN'S RECOMMENDATIONS

(1) That the 1980 House of Delegates direct the MAG Board of Directors to continue its assessment of appropriate Association goals and objectives and give serious consideration to utilizing outside consultants to assist in the development of Association goals and the selection of priorities. The Board should continue to report to the House of Delegates annually on the progress of this endeavor.

(2) That the Board of Directors immediately authorize the preparation of a proposal to increase the square footage space occupied by the Headquarters office; that if an addition to the present building is required, competitive bids be sought on costs thereof; and that the proposal, accompanied by a fiscal note, be presented at the May 31-June 1, 1980, meeting of the Board of Directors for the Board's consideration and approval.

FISCAL NOTE:

Recommendation 1, consultant's fee of $1,500, plus expenses of approximately $350.

Recommendation 2, Preliminary estimates from Architect/Builders range between $145,000 and $175,000, depending on the ultimate total square footage and interior design.



Charles D. Hollis, Jr., M.D., testifies at Reference Committee A.

REFERENCE COMMITTEE DISCUSSION

The Chairman of the Board, Dr. Joe Stubbs, outlines in his report a summary of the activities of the MAG Board for 1979-80. Dr. Stubbs' report, as did the President's report, discusses at length the goals and priorities of the Association which were approved by the Board in September of 1979.

The Chairman of the Board's report contains two recommendations. The first is to continue the assessment of the Association's goals and recommends utilizing an outside consulting firm to assist in the development of goals and priorities. The Chairman's fiscal note for such a proposal is $1,850 for the consultant's fees and expenses.

Recommendation 2 of the Chairman's report would authorize a proposal to increase the square footage of the existing MAG Headquarters building, and that, if an addition is required, the Board of Directors proceed with construction based on figures of competitive bids to range between $145,000 and $175,000.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee has previously recommended disposition of Recommendation 1.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that Recommendation 2 be amended to read as follows: (2) That the Board of Directors immediately authorize the preparation of an internal design evaluation of the entire MAG Headquarters building to be followed, if indicated, by an addition to the present building as required; and that competitive bids be sought on costs thereof; and that the proposal, accom-

panied by a fiscal note, be presented to the Board of Directors at the earliest possible date for the Board's consideration and implementation.

HOUSE OF DELEGATES ACTION

The House disposed of Recommendation 1 in the Chairman of the Board's report as outlined earlier. The House adopted Recommendation 2 as amended by the reference committee.

REPORT OF THE AMA DELEGATION

Harrison L. Rogers Jr., M.D., Chairman

The annual meeting in Chicago and the interim meeting in Hawaii were both attended by all delegates as well as alternate delegates and officers. Following each meeting, highlights of House actions were presented to MAG membership via the MAG *Newsletter* and therefore will not be included in this report. Harrison Rogers was elected to his third term as Vice Speaker of the AMA House; he also serves as an ex-officio member of the Board of Trustees of AMA. Another of our delegates, J. Dan Bateman, was named to the AMPAC Board of Directors in September, 1979.

The AMA delegation accepted the decision by Dr. F. G. "Tex" Eldridge not to seek re-election as alternate delegate with sincere regrets. Dr. Eldridge had served with distinction since 1971 and is held in high esteem by AMA delegates from all parts of the country. Dr. Carson "Bucky" Burgstiner was elected to fill this position without opposition.

Major issues faced by the House included:

1. National Health Insurance proposals with reaffirmation of our 1978 position supporting catastrophic coverage only if necessary.
2. Medical education reports for future consideration as well as the decision to withdraw from the Liaison Committee on Continuing Medical Education and instead reinstitute the AMA "Committee on Accreditation of Continuing Medical Education."
3. An interim report of the *ad hoc* committee of the House considering changes in the AMA "Principles of Medical Ethics." During 1979, this AMA committee met in Atlanta and heard testimony by Georgia physicians. Its chairman, Dr. James Todd, of New Jersey, subsequently attended a meeting of the MAG committee evaluating the proposed changes.
4. Membership and the financial position of the AMA and as of this date no increase in dues has been recommended. There are now over 40,000 student and resident physician members of AMA.

The MAG House of Delegates gave favorable consideration in 1979 to inclusion of representatives of both medical students and house staff in the MAG House. Providing the future physicians of our state with a voice in our legislative body will certainly encourage closer ties to organized medicine and will provide our members with a better view of the problems peculiar to students and housestaff.

RECOMMENDATIONS

1. That implementation of the 1979 House Action on student and house staff representation proceed expeditiously.
2. That MAG members be encouraged to attend the annual meeting of AMA House of Delegates July 20-24 in Chicago as well as the interim meeting December 7-10 in San Francisco.
3. That MAG staff investigate the feasibility of charter travel to San Francisco for December.

REFERENCE COMMITTEE DISCUSSION

The report of the AMA delegation outlines the major issues that have been addressed by the AMA House of Delegates this past year. The report contains three recommendations.

The first recommendation has been acted on previously in this reference committee's report.

The AMA delegation's second recommendation encourages attendance at the AMA House meetings.

The third recommendation is that MAG staff investigate the feasibility of a charter to the AMA San Francisco meeting.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends adoption of Recommendations 2 and 3.

HOUSE OF DELEGATES ACTION

Recommendation 1 was rejected and Recommendations 2 and 3 were approved.

REPORT OF THE MEMBERSHIP COMMITTEE

William C. Collins, M.D., Chairman

Your Membership Committee is pleased to report that as of December 31, 1979, the MAG had 4,227 dues paying members. Of those, 3,896 were full dues-paying members, and the remainder were in various other categories ranging from interns and residents to those physicians who had reached the age of 65 and pay reduced dues to the Association. At the same time, there were 3,348 dues paying members of the AMA from MAG and 428 dues-exempt members, making a grand total of AMA membership of 3,776. This is the second year in a row that MAG has received a Membership Increase Award from the AMA for increased membership. MAG is only 225 AMA members short of having a fifth delegate to the AMA House of Delegates.

Several county medical societies in Georgia have put on aggressive membership campaigns during the past year, and one has gotten one of their local hospital residency training programs to pay the dues in the county, state, and AMA for all the interns and residents in that school. Your committee sincerely hopes that each county medical society would put on a membership drive for the county, the state, and the AMA to bring as many members as are eligible into organized medicine. If this were done, not only here in Georgia but across the nation as well, it would aid greatly in holding down state and AMA dues for many years to come.

RECOMMENDATIONS

1. That each county medical society comprising the MAG establish an aggressive Membership Committee.
2. That these committees contact each physician in their respective county who is not a member of organized medicine and urge them to join the county society, MAG, and the AMA.

REFERENCE COMMITTEE DISCUSSION

The Membership Committee has given a breakdown of MAG's membership by category and makes two recommendations. The first recommendation is that each county medical society establish an aggressive membership committee. The second is that these committees contact nonmembers to join organized medicine.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that Recommendation 1 be amended to read: 1) That each county society comprising the MAG *be urged to* establish an aggressive membership campaign.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends adoption of Recommendation 2.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee would point out that we have made one other recommendation to the Membership Committee elsewhere in this report.

HOUSE OF DELEGATES ACTION

The House adopted the recommendations as amended by the reference committee.

PHYSICIANS' CONSULTANT COMMITTEE TO THE DISABLED DOCTORS PROGRAM

G. Douglas Talbott, M.D., Chairman

In September, 1975, under the leadership of Dr. Earnest C. Atkins, the MAG implemented the Disabled Doctors Plan. Great impetus was given in June 1977 when the MAG substantially funded the Disabled Doctors Program. Members of the committees that govern the program still freely contribute their time and effort. In this relatively short period of time, the MAG, through its Disabled Doctors Program, has become the national leader in the recognition, motivation, and treatment of the impaired physician. The Georgia model has been utilized in aiding other states and areas of our continent in setting up similar programs for their ill physicians. We have thus come to realize that the disease of chemical dependency affects health care professionals other than the physician, and this occupational hazard reaches into the fields of dentistry, nursing, pharmacy, etc.

Because of these facts, we have been involved with the Georgia Dental Association and the Georgia Nursing Association, and at the present time, Georgia has not only a Disabled Doctors Program but also a Disabled Dentists Program and a Disabled Nurses Program. These programs as are ours, are sponsored, administrated, and funded by their respective professional societies.

The Disabled Doctors Program has grown and progressed in many facets. In the beginning, we had the use of one halfway house for the later three phases of the Program. At the present time, we are involved with five halfway houses for our physicians and have assisted the nurses in opening two houses.

The program continues to become more involved in the field of education, with great emphasis being placed on the medical students in our state. Meetings with the students at both Emory University and the Medical College of Georgia continue to be held and have met with great enthusiasm. It is felt that this represents a substantial preventive effort on the part of the MAG for the problems of chemical dependency in physicians.

In February, 1980, the Disabled Doctors Program sponsored its annual resocialization retreat at Cohutta Lodge in Chatsworth, Georgia. At this meeting we had 110 physicians and their spouses. These are all physicians who had been involved in the Disabled Doctors Program. This year an addition was made to the usual weekend: the Disabled Doctors Program sponsored a full-day education seminar, with continuing medical education credits available.

There have been many new and exciting happenings with MAG's Disabled Doctors Program in the past year, but time does not permit full discussion. The most rewarding event, however, is the increasing number of impaired physicians who have returned to a happy and productive practice of medicine. The number is 136 as of March 1, 1980.

This is the MAG's program, and the success attained thus far is due to the support of our state medical society.

RECOMMENDATIONS

The committee's report contained no recommendations but was referred to the House by the Board of Directors.

REFERENCE COMMITTEE DISCUSSION

This report contains no recommendations and has been previously commended by the President and is also commended by your reference committee. It is an outstanding program that has been recognized as a model for the nation.

HOUSE OF DELEGATES ACTION

The House commended the Committee.

MEDICAL PRACTICE COMMITTEE — SUPPLEMENTAL REPORT

W. Daniel Jordan, M.D., Chairman

At its March, 1980, meeting, the MAG Executive Committee directed the Medical Practice Committee to utilize legal counsel's redraft of the MAG policy on Podiatry, gather pertinent data on past actions of the Association, and make a specific recommendation in its annual report to the House in April. MAG is at present

undergoing an investigation of its policy toward Podiatry by the Federal Trade Commission.

The committee members have reviewed:

1. The current (1974) MAG policy on podiatrists,
2. The chronology of statements concerning podiatry from September 1970 to February 1978,
3. The resolution that passed the House of Delegates in 1979 noting the deletion of podiatrists from the adopted resolution,
4. The letters from Mr. Dick Vincent (MAG's legal counsel) to MAG (January 24 and February 8),
5. The AMA position statement on podiatry,
6. The revision of policy suggested by Mr. Vincent.

The current MAG policy states:

"The MAG opposes hospital staff privileges for podiatrists, but declares it is not unethical for physicians to treat patients jointly with podiatrists in a hospital setting where this is permissible by the medical staff." (This paragraph has been reaffirmed by Council, i.e., Board of Directors, 1971; Executive Committee, 1972; and Executive Committee, 1974.)

"The MAG declares that podiatry is not the practice of medicine, and that podiatrists are doctors of podiatric medicine, not doctors of medicine." (This paragraph was reaffirmed by Executive Committee in 1971, February 1972, June 1972, and July 1972; by the 1972 House of Delegates; by the Board of Directors, 1972; and by the 1974 Executive Committee.)

The MAG legal counsel suggests the following:

"The MAG recognizes that a podiatrist is not a full-practice physician. By training and experience, a podiatrist's area of concern is limited to a portion of the body. The MAG also recognizes that podiatrists are licensed only to perform 'diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment . . . of the human foot and leg' and are not licensed to 'do any amputation or use any anesthetic under other than local.'

The MAG also recognizes that no license to practice medicine (whether full or limited) confers a constitutional right to practice that profession in a hospital. The MAG supports the right of a hospital to deny staff privileges to a class of limited health care practitioners who are licensed by the state, so long as such exclusion has a rational basis and is reasonably related to the operation of the hospital.

The MAG reaffirms its basic tenet in support of providing patients with the highest quality of medical care at a fair price. Decisions regarding staff privileges and use of in-hospital medical facilities by limited licensed practitioners should be made with this tenet foremost in mind."

After review of the materials listed, the Medical Practice Committee considered three options:

1. No change,
2. Adopt attorney draft, or
3. Revise or develop a new position,

but was unable to arrive at a single conclusion by a clear majority.

RECOMMENDATION

The Medical Practice Committee recommends that MAG's position on podiatry be referred to the April, 1980, House of Delegates for action as it deems advisable.

REFERENCE COMMITTEE DISCUSSION

The report outlines its efforts in reviewing MAG's policy on podiatry. The Medical Practice Committee recommends that the MAG position on podiatry be referred to this 1980 House for action as it deems advisable.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that MAG's policy on podiatry be as follows: "The MAG recognizes that a podiatrist by training, experience, and statute, is a limited practitioner.

The MAG also recognizes that no professional license confers a constitutional right to practice that profession in a hospital. The MAG supports the right of a hospital to deny staff privileges to a class of limited health care practitioners who are licensed by the state, so long as such exclusion has a rational basis and is reasonably related to the operation of the hospital.

The MAG reaffirms its basic tenet in support of providing patients with the highest quality of medical care at a fair price. Decisions regarding staff privileges and use of in-hospital medical facilities by limited licensed practitioners should be made with this tenet foremost in mind."

HOUSE OF DELEGATES ACTION

The House adopted the Reference Committee's amended policy statement on podiatry.

RESOLUTION 1
LEGAL APPROVAL OF MAG RESOLUTIONS

Muscogee County Medical Society

WHEREAS, at the Annual Session of the House of Delegates of the MAG there is a rush for time and debate if often heated, and

WHEREAS, resolutions are passed with good intent but contain improper wording or structure that may precipitate later legal actions, and

WHEREAS, legal counsel is present but does not have time to analyze all resolutions, then,

RESOLVED, that all resolutions passed by the House of Delegates at the Annual Session be referred to legal counsel prior to final implementation for wording, legality, and constitutionality. If changes are made but not the intent the final approval be made by the Board of Directors for implementation. If illegal or the intent is changed, then said resolution be referred back to House of Delegates at next Annual Session.

REFERENCE COMMITTEE DISCUSSION

This resolve portion of this resolution proposes that all resolutions passed by the House of Delegates shall be referred to legal counsel prior to final implementation for approval of wording, legality, and constitutionality and proceeds to discuss the procedure to be followed if judged by counsel to be illegal.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends Resolution 1 be amended by deletion and substitution of the following resolve: "All reports and resolutions submitted to the House of Delegates must be submitted at least 30 days prior to the convening of the House in order to allow legal counsel sufficient time for review. This shall take effect for the 1981 session of the House. Should any resolution or report not meet the 30-day requirement, in order to be considered, a three-fourths affirmative vote of the House would be required.

HOUSE OF DELEGATES ACTION

The reference committee amended the resolution by substitution, and the House rejected the substitution which was the main motion.

RESOLUTION 11
MEMBERSHIP OF THE AMERICAN MEDICAL ASSOCIATION (AMA)

Cobb County Medical Society

WHEREAS, the membership of the AMA has been declining over the past years, and

WHEREAS, physicians in the private section are not renewing their AMA memberships, and

WHEREAS, dues-paying members are concerned about the AMA and its membership loss, and

WHEREAS, these physicians are becoming disenchanted with AMA leadership, therefore, be it

RESOLVED, that the President of AMA be elected by the dues paying and life members of the AMA by a direct mail ballot, and be it further

RESOLVED, that the President of AMA serve a 4-year term with a right of succession of a second 4-year term, and be it further

RESOLVED, that the President's salary be commensurate with the duties and responsibility of the office, and be it further

RESOLVED, that if this resolution is approved by the MAG House of Delegates, it be introduced by the MAG AMA Delegation in the July 1980 AMA House of Delegates meeting.

REFERENCE COMMITTEE DISCUSSION

The resolution outlines a new procedure for election of the AMA president. It would provide for a direct-mail ballot, a 4-year term, a salary commensurate with his duties, and that, if approved by this MAG House of Delegates, the MAG delegation will introduce the proposal in the AMA July, 1980, House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee agrees with the "Whereas" portion of the Resolution and recommends adoption of the first "resolve" of Resolution 11.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that the second resolve be amended to read, "RESOLVED: that the President of the AMA serve a 2-year term with the right of succession of two additional 2-year terms; and be it further, ... "

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends adoption of the third resolve.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your reference committee recommends that the fourth resolve be amended to read, "RESOLVED, that if this resolution is approved by the MAG House of Delegates, after proper wording to accomplish the necessary AMA Constitution and Bylaws changes, it be introduced by MAG's AMA Delegation during the July 1980 AMA House of Delegates' meeting."

HOUSE OF DELEGATES ACTION

The House approved the first resolve of the Resolution. The House approved the second resolve as amended by the Reference Committee. The House approved the fourth resolve as amended by Delegate Robert Wells, M.D., of Atlanta, as follows: RESOLVED, that the MAG AMA Delegation introduce a resolution into the AMA House of Delegates directing that House to appoint a committee of the House to evaluate this and any other recommendations regarding methods of election and tenure of the AMA President.

This concluded the report of Reference Committee A. Chairman Sherman expressed appreciation to each member of this committee for their diligence in pursuit of their duties as members of this committee and expressed a special appreciation to all of those who participated in the deliberations. The committee is especially grateful for the able assistance of Mr. Ken Williams and Mr. Bob Brown of the MAG staff.


Medigram
DEAR DOCTOR ...
COME AND JOIN US FOR THE 1980 MAG SCIENTIFIC ASSEMBLY.
NOVEMBER 21-23 OMNI INTERNATIONAL HOTEL, ATLANTA.
FEATURING:
PROGRAMS IN 17 SPECIALTIES
AMA CATEGORY 1 CREDIT
AAFP AND ACEP CREDIT
SPECIAL MAG SESSION: NUTRITION
ALUMNI RECEPTIONS
SEE YOU THERE.
M A G



Members of Reference Committee D include (L-R) MAG Staff person Steve Daniel, Ph.D., and Drs. Charles A. Lanford, Macon; Bradwell R. McAlister, Gainesville, Spencer S. Brewer, Jr., Atlanta, Chairman; J. Moultrie Lee, Savannah, Vice-Chairman; McAlpin H. Arnold, Elberton. Not shown are Dr. Alva Louie Mayes, Jr., Macon, and Sheila Carson, MAG Staff.

Report of Reference Committee D

Spencer S. Brewer Jr., M.D., Chairman
J. Moultrie Lee, M.D., Vice-Chairman

Chairman Brewer reported that Reference Committee D met in the State Room at the Atlanta Hilton Hotel on Friday, April 25, and gave careful consideration to all items referred to it.

COMMITTEE ON ACCESS TO HEALTH CARE

M. Julian Duttera Jr., M.D., Chairman

The Committee on Access to Health Care is pleased to report considerable progress on its recommendations adopted by the 1979 House of Delegates of the MAG. Among these accomplishments are the computerization of the physician placement service, the Third Annual Pre-Practice Seminar and Physician Recruitment Conference held at Callaway Gardens, the development of a form to solicit county medical society input into the placement of National Health Service Corps (NHSC) physicians, and the development of the concept of a totally private physician placement service.

The computerization of the MAG physician placement service has been completed. The computer service is now able to print the name, specialty, and other pertinent important information on each physician who indicates an interest in practicing in the State of Georgia. The service also provides physicians with a list of the opportunities available to them in the state. An aggressive effort on the part of the committee is being made to seek primary care physicians to register with the placement service. After a 6 to 9 month period, the service will be carefully evaluated as to its effectiveness in placing physicians and increasing the number of primary care physicians and opportunities listed.

The committee is extremely pleased to report that there is now a mechanism to insure that county medical societies will have input into the placement of NHSC physicians in Georgia. Representatives of the committee met with the officials of the Department of Health, Education, and Welfare (DHEW) in Atlanta. Also present at that meeting were representatives of each of the state's Health Systems Agencies (HSAs). The need for county medical society input into the placement of these physicians was emphasized. As a result of that meeting, a form was designed by the committee and subsequently adopted by the Region IV Office of Public Health Service to solicit county medical society comments on NHSC physician applications. This form has been sent to all HSAs in the state and to Region IV staff in the DHEW. It will become a part of the application from local communities for NHSC staff. Each county medical society will be alerted to the existence of this form by the MAG office. We have been assured by DHEW staff that this form will be used in Georgia. The committee will closely monitor this activity to insure that county medical societies are involved in the placement of NHSC physicians.

A most successful Pre-Practice Seminar and Physician Recruitment Conference was held at Callaway Gardens in October 1979. In addition to the MAG, the conference was sponsored by the Southeastern Institute for Community Health, the Georgia Academy of Family Physicians, and the Joint Board of Family Practice. A total of 60 physicians and representatives from 42 communities attended the meeting. At least eight physicians already have been placed as a result of the first two conferences, and we expect additional physicians to be placed as a result of this third conference.

The State Medical Education Board of Georgia also sponsored its first Health Fair to recruit physicians as part of its scholarship program. This conference was held in Augusta immediately following the Pre-Practice Seminar at Callaway Gardens. An attempt was made by the committee to cooperate with the State Medical Education Board on the 1980 Pre-Practice Seminar. However, the State Medical Education Board found it was not able to

work with us this year. We hope that in future years we will be able to cooperate with the Board jointly in sponsoring physician placement conferences in the state.

At its January 1980 meeting, the MAG Board of Directors endorsed a committee recommendation calling for the development of a private physician placement service sponsored by the MAG, the Georgia Academy of Family Physicians, the Joint Board of Family Practice, the Southeastern Institute for Community Health, other specialty societies, and other private organizations interested in placing physicians in rural Georgia. The need for this type of service is apparent. It is clear that only the private sector will be able to find a long-term solution to the problem of physician maldistribution. At this time, no definite plans have been made to implement or fund this service. However, it is apparent that unless the private sector takes a lead role in placing physicians, the federal and state governments will continue to dominate the placement of physicians in rural areas to the exclusion of the private sector.

RECOMMENDATIONS

The following recommendations are made by the committee:

1. That MAG continue to support the Pre-Practice Seminar and Physician Recruitment Conference both in sponsorship and financial commitment during the 1980 year;
2. That the MAG House of Delegates wholeheartedly support the position taken by the Board of Directors at its January, 1980, meeting by endorsing the concept of a private physician placement service in Georgia, no funds for which are needed at this time;
3. That MAG aggressively expand its computerized placement service and after a 6 to 9 month period evaluate its performance to determine the effectiveness of the service in placing physicians in Georgia.

REFERENCE COMMITTEE DISCUSSION

This report summarizes the activities of the committee over the past year. Among its accomplishments are the computerization of the physician's placement service, the Third Annual Pre-Practice Seminar and Physician's Recruitment Conference held at Callaway Gardens, the development of a form to solicit county medical society input into the placement of NHSC physicians, and the development of a concept of a totally private sector physician placement service. The report contains three recommendations: (1) That the MAG continue to support the Pre-Practice Seminar both in sponsorship and financial commitment during the 1980 year; (2) That the MAG House of Delegates support the position taken by the Board of Directors in its endorsement of the concept of a private physician placement service in Georgia; (3) That the MAG expand its computerized placement service and, after a 6 to 9 month period of evaluation, determine its effectiveness in placing physicians in Georgia.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee commends the Committee on Access to Health Care and recommends adoption of the recommendations made in its report.



MAG's Executive Director James M. Moffett and his Administrative Assistant, Miriam McLendon, study the committee reports presented in the Second Session of the House of Delegates.

HOUSE OF DELEGATES ACTION

Adopted the recommendations of the report.

RESOLUTION 5
ROBERT CUMMING WILSON

WHEREAS, Robert Cumming Wilson was born in Sparta, Georgia, on October 27, 1878;

WHEREAS, He is a graduate of the University of the South School of Pharmacy at Sewanee, Tennessee;

WHEREAS, He served as a faculty member of the University of Georgia School of Pharmacy from 1907 through 1949;

WHEREAS, He was dean of Pharmacy from 1914 through 1949;

WHEREAS, He served as President of the American Association of Colleges of Pharmacy in 1936;

WHEREAS, He served as Chairman of the House of Delegates of the American Pharmaceutical Association in 1937;

WHEREAS, He served as Vice-President of the U.S. Pharmacopoeial Convention in 1940;

WHEREAS, He served as Honorary President of the American Pharmaceutical Association;

WHEREAS, He served as mentor and as an inspiration by his sterling character to thousands of pharmacy students;

WHEREAS, He molded one of the nation's outstanding schools of pharmacy;

WHEREAS, The Board of Regents of the University System of Georgia has honored his accomplishments by naming the School of Pharmacy Building at the University of Georgia the Robert C. Wilson Building;

WHEREAS, He is one of Georgia's outstanding sons,

RESOLVED, that the House of Delegates of the MAG salutes Robert Cumming Wilson in the one hundred and second year of his birth and thank him for his outstanding contributions to the cause of public health.

RESOLVED FURTHER, that this resolution be suitably prepared and signed by the appropriate officers of the MAG and presented to Dean Wilson.



As Dr. Earnest C. Atkins (L) studies the report of the Education Committee, Drs. Carson Burgstiner, and H. Hilt Hammett, Jr., (R) carry on a hushed dialogue.

REFERENCE COMMITTEE DISCUSSION

This resolution gives recognition to this 102-year-old pharmacist for his outstanding contributions to the cause of public health. He served as a leader between pharmacy and medicine, and many MAG members were taught and inspired by him. This resolution is to salute him and to thank him, with the resolution to be signed by appropriate officers of the MAG and presented to Dean Wilson.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 5 be adopted.

HOUSE OF DELEGATES ACTION

Adopted Resolution 5.

CANCER COMMITTEE

J. Moultrie Lee, M.D., Chairman

The Cancer Committee has met on occasions in the year to consider several different subjects.

The committee met and discussed in depth the use of marijuana in the treatment of the cancer patient. The committee passed a resolution "that the MAG go on record as favoring legislation in Georgia that will permit the use of marijuana in medical research for testing the effectiveness of this substance in the care of the patient with cancer." The Executive Committee subsequently accepted this resolution.

The Cancer Committee reaffirmed its position of support of the Governor's Cancer Advisory Committee and its recommendation for community based cancer programs.

Members of the Cancer Committee and the Cancer Advisory Subcommittee met in joint session with staff members of the Cancer Information Service from the comprehensive Cancer Center in Miami, Florida. The National Cancer Institute provides funding for the Cancer Information Service (CIS). The CIS is a telephone service with a toll free WATS line covering the state of Florida. This telephone service is to be extended into Georgia and continue to be based in Miami, Florida. The CIS was requesting approval by MAG of this extension of this toll-free service into Georgia. Although the combined Cancer Committee — Cancer Advisory Subcommittee group approved this extension, the approval was far from unanimous. The members of the Cancer Committee itself were divided on the subject and, therefore, could not give recommendation as to what action MAG should take. Information gathered at the meeting with the CIS staff was, therefore, forwarded to the Board of MAG so that that body could take action.

The Chairman wishes to extend his deep appreciation to the members of the committee for their invaluable aid, their interest, and cooperation throughout the past year.

REFERENCE COMMITTEE DISCUSSION

The annual report summarizes the year's activities of the committee as it dealt with the use of marijuana in medical research, its support of the Governor's Cancer Advisory Committee, and the Cancer Advisory Subcommittee's role in consideration of approval of the Cancer Information Service based in Miami, Florida. This report contains no recommendations.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that this report be received for information with commendation.

HOUSE OF DELEGATES ACTION

Received the report of the Cancer Committee for information with commendation.

SUPPLEMENTAL REPORT OF THE CANCER COMMITTEE

J. Moultrie Lee, M.D., Chairman

At its March 16, 1980, meeting, the Executive Committee requested the Cancer Committee "to develop a policy statement condemning the general use of marijuana that henceforth will become a part of the statement adopted by the January Board supporting the experimental use of marijuana for glaucoma and cancer patients."

The Cancer Committee recommends that the following become the MAG policy:

RECOMMENDATION

The MAG supports the present legislation in Georgia that permits the use of marijuana in a strictly controlled medical research program for testing the effectiveness of the substance in the care of patients with cancer or glaucoma. The MAG condemns the use of marijuana and any of its cannabinoid derivatives, such as Δ^9-tetrahydrocannabinol (THC) for general (recreational) use or for any purpose other than medical research.

REFERENCE COMMITTEE DISCUSSION

The Supplemental Report of the Cancer Committee deals with the development of a policy statement regarding the use of marijuana. Testimony revealed that there is some fear that the recent bill as passed by the Georgia legislature with the support of the MAG

might be misinterpreted as the advocacy of the general use of marijuana. The recommendation calls for support by the MAG of the present legislation in Georgia permitting the use of marijuana in a strictly controlled medical research program. It also calls upon the MAG to condemn the use of marijuana and certain derivatives for general (recreational) use.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the recommendation be divided into two parts in order to insure proper emphasis. The first part reads: "The MAG supports the present legislation in Georgia that permits the use of marijuana in a strictly controlled medical research program for testing the effectiveness of the substance in the care of patients with cancer or glaucoma." The second part of the committee's recommendation is to be amended so that it reads: "The MAG strongly condemns the use of marijuana and any of its cannabinoid derivatives such as Δ^9-tetrahydrocannabinol (THC) for general (recreational) use or for any purpose other than medical research." Mr. Speaker, your Reference Committee recommends adoption of the two-part recommendation as amended.

HOUSE OF DELEGATES ACTION

Adopted the recommendation of the Cancer Committee as amended.

COMMITTEE ON EDUCATION

Edwin C. Evans, M.D., Chairman

The charge to the committee is as follows: "The Education Committee shall work to foster the development of high quality continuing education programs for physicians throughout the state. It shall also promote comprehensive health education in the schools, patient education, and health education for the general public. The Committee shall maintain liaison with the medical schools and with other institutions and agencies which provide medical and health education."

The Education Committee is composed of 39 members, many of whom have been active in a number of capacities during the year. In addition, meetings of the committee were held on June 6, 1979, October 3, 1979, and February 6, 1980. The Sub-Committees on Accreditation, Hospital CME, and Medical Schools met immediately preceding each session of the main committee. The Health Education Sub-Committee met on four occasions with their invited group of leaders in the health education field. "MAG Priorities and Goals for Health Education" (see Supplemental Report of this committee) represents evidence of the dedication of the Health Education Sub-Committee to carry out its charge.

On July 25, 1979, the AMA House of Delegates voted to withdraw the AMA from membership in the Liaison Committee on Continuing Medical Education (LCCME) immediately and simultaneously resume responsibility for the voluntary accreditation of CME through the establishment of a Committee on Accreditation of Continuing Medical Education (CACME) under the AMA Council on Medical Education. This highly significant move essentially reactivated an accreditation system that existed for more than a decade preceding the undertaking of the accreditation process by LCCME on July 1, 1977. After AMA withdrew from LCCME last July, MAG was notified by the AMA Council on Medical Education in a memorandum dated July 30, 1979, that the State Medical Society (i.e., the Education Committee of MAG) is recognized as the accrediting body for the institutions and organizations providing local and intrastate CME programs in Georgia. The state programs for survey and accreditation by our Committee now operate under CACME. Organizations providing national or regional CME will have their program surveys and accreditation by CACME. In late October, 1979, the Secretary of LCCME requested by letter a list of organizations/institutions approved for accreditation by MAG. Upon recommendation of the Education Committee the MAG Executive Committee approved November 18, 1979, the following position statement:

> "The MAG supports the AMA as the national accrediting agency for continuing medical education and will provide the AMA's Committee on Accreditation of CME with information on the institutions and organizations which the MAG has accredited. The MAG will not provide this information to other organizations."

The controversy between LCCME and AMA will probably continue for some time before a satisfactory solution is found. However, it is important to recognize that the capability of MAG to accredit CME programs within the state promises to continue for a long time and probably does not hinge upon the outcome of that controversy. But we must continue to insist that the accreditation system(s) address the needs of practicing physicians and that both state and medical specialty societies are involved in the development and execution of policy and respect to CME.

The following Georgia institutions and organizations are accredited for their CME programs:

American Academy of Pediatrics, Georgia Chapter
American Cancer Society, Georgia Division
American College of Chest Physicians, Georgia Chapter
American College of Physicians, Georgia Chapter
Athens General Hospital/St. Mary's Hospital, Athens
Atlanta Graduate Medical Assembly
Atlanta Society of Pathologists
Center for Disease Control (CDC)
DeKalb General Hospital, Decatur
Emory University School of Medicine and affiliated hospitals
Georgia Academy of Family Physicians Educational Foundation
Georgia Baptist Hospital, Atlanta
Georgia Heart Association
Georgia Psychiatric Association
Georgia Radiological Society
Georgia Rheumatism Society
Georgia Society of Anesthesiologists
Georgia Society of Ophthalmology

Georgia Surgical Society
Greater Atlanta Otolaryngology Society
Martin Army Hospital, Fort Benning
Medical Association of Georgia
The Medical Center, Columbus
Medical Center of Central Georgia, Macon
Medical College of Georgia and affiliated hospitals
Memorial Medical Center, Savannah
Northside Hospital, Atlanta
Phoebe Putney Memorial Hospital, Albany
Piedmont Hospital, Atlanta
Scottish Rite Hospital, Atlanta
South Fulton Hospital, East Point
Southeastern Angiographic Society
Tanner Memorial Hospital, Carrollton
University Hospital, Augusta
West Georgia Medical Center, LaGrange
West Paces Ferry Hospital, Atlanta

The following activities of the Education Committee are listed by sub-committee:

A. Accreditation Sub-Committee — Dr. James Maughon, Chairman
 1. Conducted site surveys of three hospitals — South Fulton Hospital, East Point; West Georgia Medical Center, LaGrange; and Americus and Sumter County Hospital.
 2. Conducted re-surveys of nine already-accredited organizations.
 3. Sent requested accreditation application materials to 12 hospitals, two specialty societies, one medical society, six medical organizations, and one clinic.
 4. Adopted a procedure for reconsideration and appeal of adverse accreditation decisions. This decision was subsequently approved by the Executive Committee and used to resolve one particular case.

B. Hospital CME Sub-Committee — Dr. C. Dan Cabaniss, Chairman
 1. Organized and funded eight regional directors of hospital CME for the purpose of promoting the development of quality CME programs in hospitals throughout the state.
 2. The CME Regional Director and the MAG Director of Education conducted an evening workshop in Albany for chairmen of hospital CME in that region. Five hospitals were represented. A similar workshop is planned for Savannah.
 3. The MAG Director of Education traveled to hospitals in Augusta, Dalton, and Atlanta to promote CME.

C. Medical Schools Sub-Committee — Dr. Lois Ellison, Chairman
 1. Co-sponsored with the medical schools the Eighth Conference on Medical Education, which brought together representatives of academic medicine and private practitioners at the MAG Scientific Assembly for discussion of philosophies and priorities of medical education in Georgia.

D. Health Education Sub-Committee — Drs. Nicholas Davies and John Harrel, Co-Chairmen
 1. Coordinated the sharing of information about health education programs through regular meetings of the Health Education Group (under the committee's aegis) which includes representatives of many of the various organizations and agencies active in this field.
 2. Created a position statement on health education which contains goals, priorities, and recommendations for adoption by the 1980 House of Delegates (see Supplemental Report).
 3. Sent reprints of the special issue of the *JMAG* on teenage pregnancy to all state legislators with a cover letter requesting support for funding of programs designed to combat problems in this area. Also sent reprints to all school superintendents and health departments.
 4. Provided leadership of the special medical advisory committee to assist WSB-TV in planning the 1980 Atlanta Health Fair.
 5. Testified at a Georgia House Sub-Committee meeting on the importance of health education in the schools.
 6. MAG Director of Education attended a 2-day Patient Education Conference and was a featured speaker at another conference on Health Promotion and Prevention — Topic was the "Role of the Medical Association in Health Education."
 7. Committee is currently working with the Committee on Cost Awareness to produce a patient education brochure for the physician's office.

Additional Activities of MAG Education Committee:

(1) Disseminated the position statement on CME to all physicians, hospitals, and specialty societies.
(2) Maintained a Medical Meeting Calendar of all CME meetings in Georgia and contiguous states (published monthly in *JMAG*).
(3) Helped plan the 1979 MAG Scientific Assembly.
(4) Sponsored two "Starting Your Practice" workshops for residents about to enter private practice and a workshop for medical office managers.
(5) Promoted the Physicians' Recognition Award by setting a goal of having every MAG member qualify for the award by 1985. Also sponsored an exhibit on the award at the 1979 MAG Scientific Assembly. In addition, a MAG seal was added and a cover letter is being sent with each PRA Certificate awarded to a Georgia physician by the AMA. Names of PRA recipients are also published in *JMAG*.
(6) Sponsored a seminar on "Private Enterprise Perspectives on Medicine" May 26-27, 1979. An article on this seminar was featured in the December 15, 1979, issue of *Patient Care* magazine.
(7) Attempted to find an Atlanta-area FM radio station willing to carry the Physicians Radio Network on a side band. This attempt has been unsuccessful.
(8) Helped plan and promote a series of CME programs via live telephone on the Georgia Hospital Association's new telecommunications network.

(9) Helped plan a seminar on medical libraries, new information technology, and CME.
(10) Helped plan and sponsor a CME meeting on gerontology.
(11) Sponsored three prizes of savings bonds for winners in the Annual Georgia Science and Engineering Fair.

The chairman expresses his thanks especially to the many members of the Education Committee for their continuing enthusiasm and support; to the sub-committee chairmen for their tireless efforts; to the various members of the Health Education Group, especially Representative Dorothy Felton; and to Dr. Stephen Daniel of the MAG Staff for his diligence, for his tenacity, and for the pleasant and efficient manner in which he performed for the Committee.

REFERENCE COMMITTEE DISCUSSION

The annual report summarizes the committee's activities over the past year.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the report be received for information with commendation to the committee and its chairman.

HOUSE OF DELEGATES ACTION

Received the report of the Education Committee with commendation.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON EDUCATION

Edwin C. Evans, M.D., Chairman

MAG PRIORITIES AND GOALS FOR HEALTH EDUCATION

Health is everybody's business. Often it appears to be nobody's. Despite the advances made during the 20th century in medical knowledge and the health care system, our American society is still beset with major health problems. These include infant mortality, problems related to teenage pregnancy, venereal disease, suicide, malnutrition, obesity, alcoholism and drug abuse, tobacco-related illnesses, mental illness, hypertension, cardiovascular disease, cancer, and motor vehicle accidents.

Several statistics will serve to highlight the problems. In 1900, only 16% of all deaths in the United States were attributable to cardiovascular diseases and only 4% to cancer. This contrasts markedly with the statistics for 1977, which show 50% of all deaths from cardiovascular diseases and 20% from cancer. Accidents, homicides, and suicides now account for about three-fourths of all deaths among teenagers and young adults, an age group which has had a steady rise in the death rate during the last 2 decades.

Turning to our own state, Georgia's infant mortality rate in 1977 was 17 out of every 1,000 live births, putting us among the 12 states with the highest rates. Georgia ranks third in the nation in incidence of teenage pregnancies, with over 26,000 each year since 1974. In 1977, one out of every 12 teenage girls had a baby, and these births constituted half of the out-of-wedlock births in Georgia. In addition, teenagers obtained one-third of the state's 25,552 abortions in 1977.

If we merely treat people who show the *effects* of health problems, the problems will only persist and intensify. What is needed is a coordinated attack upon the *causes* of the problems — a strategy aimed at preventing the problems from arising. Education for good health lies at the heart of such a strategy, since it is ultimately the individual who must take responsibility for his or her own health.

The Constitution of the MAG states that the purpose of the Association is "to promote the science and art of medicine *and the betterment of public health*." The MAG, therefore, regards health education as a top priority and commits itself to leadership in the field.

We define health education as a variety of learning experiences which:

a) *inform* people about health, illness, and ways in which they can improve and protect their health;

b) *motivate* people to want to change voluntarily to more healthful practices;

c) *help* people to acquire the necessary skills to adopt and maintain healthful practices and lifestyles.

To carry out its responsibility in the field of health education, the MAG establishes the following specific priorities and goals and charges its members to implement them in every way possible.

A. Health Education in Schools
 1) *Goal:* The MAG should mount a campaign to make parents and the public aware of the need for comprehensive health education in schools, with special attention to goals #2-4 which follow.
 Method: The MAG will conduct a public awareness campaign with 30-second public service announcements on radio, especially prior to school openings each year. The MAG will also attempt to use the newspaper and television media in this campaign.
 2) *Goal:* Comprehensive health education should be integrated into the curriculum in grades kindergarten through eighth in every school and should be taught as a discrete subject in every secondary school.
 Method: Individual physicians will take an active role in persuading local superintendents, school board members, PTA groups, and community leaders to make health as important a part of the curriculum as the three R's. Capitalizing on their standing in the professional and business communities, physicians will work to obtain adequate resources, including funding, for school health courses.
 3) *Goal:* All health teachers should receive appropriate training in health education.
 Method: The MAG will promote legislation requiring that those teaching health courses at the secondary level be trained and certified in health as a subject discrete from physical education and science. The MAG will seek to provide and pro-

mote staff development courses in health education for kindergarten through eighth grade teachers statewide. Arrangements for college credit should be pursued.

4) *Goal:* The content of health courses should be accurate and consistent with sound medical theory and practice, including preventive measures, and relevant to the disease trends of the present time.
Method: Physicians will urge those in charge of curriculum at individual schools to give members of the medical community, allied health professionals, and health organizations a role in advising on the content of health courses for accuracy and soundness. Physicians in each community will also make themselves available to assist health teachers in the classroom and provide health education activities (such as field trips) outside the classroom.

B. Patient Education

1) *Goal:* Physicians should know and practice the art of educating their patients about both illness and preventive health measures.
Method: Physicians will make every effort to include in their practice of medicine the education of each patient about the nature and care of his or her malady as well as the general ways to maintain good health. Physicians will not assume that they are experts at patient education but will take the time to learn about effective techniques from those who are most knowledgeable. If a physician lacks time to educate a patient, he or she should delegate this task to an office nurse or assistant or to a patient educator in the hospital or clinic. Realizing that they set a powerful example for their patients, physicians will strive to maintain good personal health habits. The MAG will assist physicians by supplying them with patient education brochures and information about patient education resources.

2) *Goal:* Patient education programs should be adequately funded and should receive the cooperative support of the entire staff in every hospital.
Method: Physicians will urge hospital administrators and board members to see to it that patient education services are provided in every hospital, clinic, and doctor's office. Physicians will establish a good working relationship with hospital patient educators and take an active interest in seeing that these educators are well-trained and well-utilized.

C. Health Education of the Public

1) *Goal:* The MAG should be prominent in educating the public about good health practices and the processes of disease.
Method: The MAG, through its Committees on Education and Public Relations, will develop and produce health education programs suitable for communication by print, radio, and television media. Physicians in each community will make themselves available to the media for programs or articles in which an aspect of health is the topic.



Milton I. Johnson, M.D., from Macon reads a report to the Speaker.

County medical societies will solicit the help of other civic groups to put on public health forums and health fairs. Physicians will try to bring to the public's attention erroneous or harmful health information conveyed through the media and advertising.

2) *Goal:* Regional health systems agencies (HSAs), in coordination with and with the active support of the MAG and other appropriate agencies, should assume the role of coordinating health education programs of the various health organizations, agencies, and institutions.
Method: The MAG will encourage the HSAs to convene regional coalitions of health organizations, agencies, and institutions for the purposes of coordinating health education efforts, pooling resources, avoiding duplication of programs, setting priorities and goals for health education, lobbying for legislation and funding in support of health education, and sharing news about successful health education programs.

D. Health Education in Industry

1) *Goal:* The medical profession should be active in educational programs designed to keep people healthy in their work.
Method: The MAG, along with other organizations like the voluntary health agencies and insurance firms, will assist companies in creating a health program specifically appropriate to their employees which both educates them about health and safety in the workplace and provides them with opportunities to maintain healthful practices. Such programs might include risk identification, screening and referral for diseases, physical fitness, diet and nutrition, stress management, smoking cessation, management of alcohol and sub-

stance abuse, first aid and safety, cardiopulmonary resuscitation, and pre-retirement counseling.

2) *Goal:* Physicians should be informed of and involved in development of health promotion programs in industry.
Method: Local physicians will become active in providing health education and promoting programs in business and industry. MAG's Occupational Health Committee, in liaison with MAG's Education Committee, will provide continuing medical education for health in industry. Medical schools will make occupational health and hygiene a part of the medical school curriculum.

RECOMMENDATION

That the MAG adopt as policy the document, "MAG Priorities and Goals for Health Education," and that the MAG implement the methods suggested for achieving the goals.

REFERENCE COMMITTEE DISCUSSION

The Supplemental Report of the Committee on Education is a document entitled, "MAG Priorities and Goals for Health Education." It sets out a number of goals and methods to achieve these goals in the areas of health education in schools, patient education, health education of the public, and health education in industry. This report contains the recommendation that the MAG adopt as policy this document, and that the MAG implement the methods suggested for achieving the goals. The key point throughout the document is that physicians should be involved in all aspects of educating their patients and others regarding health.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee is in full agreement with the goals and methods stated in this report, and urges adoption of the document as MAG policy.

HOUSE OF DELEGATES ACTION

Adopted the supplemental report "MAG Priorities and Goals for Health Education" as MAG policy.

COMMITTEE ON HEALTH PLANNING

Thomas J. Anderson Jr., M.D., Chairman

This past year, the Committee on Health Planning carried on the work begun by Red Chambers, whose death was a loss not only to this committee but to organized medicine at all levels. Dr. Chambers worked tirelessly for 3 years to involve physicians in health planning. We are pleased to report that we are making considerable progress in this area and hope to increase physician involvement in health planning even more in the coming year.

In the past year, the committee focused its efforts in four major areas. Our primary activities have been submitting comments on the Draft Preliminary State Health Plan, involving physicians and the MAG Auxiliary at the local level in their HSAs both individually and through task forces, commenting on rules and regulations for Georgia's Certificate of Need Program, and monitoring federal funds reviewed by the state's HSAs.

GEORGIA STATE HEALTH PLANNING AND DEVELOPMENT AGENCY: The major activity of the committee has been the coordinating of comments on the Draft Preliminary State Health Plan. This Plan was issued by the Georgia State Health Planning and Development Agency (SHPDA). This is a 5 year Plan which will guide the development of health services throughout the state, and which supersedes all plans published by the state's HSAs. More than 50 physicians assisted the Committee on this, and more than 80 pages of comments were submitted by MAG on a total of 14 portions of the Plan. SHPDA has indicated that many of these comments will be considered in revising the Plan, specifically in the areas of primary care, cardiovascular disease, and radiation therapy. Other portions of the Plan on which MAG submitted comments are: computerized tomography, nursing home services, emergency medical services, end stage renal disease, general hospital beds, health policy, mental illness and substance abuse, maintenance care, pediatric inpatient hospital services, and perinatal disease. The full impact of our comments will not be known for several months, but the Committee on Health Planning expects to continually communicate with SHPDA concerning this State Health Plan to insure that physicians have adequate input into future revisions of this document. The committee also hopes to utilize the Statewide Health Coordinating Council, once appointed, as a vehicle for having input into the State Health Plan.

The second major activity in which the committee has been involved with SHPDA is Certificate of Need (CON) Rules. SHPDA issued preliminary Rules in June of 1979. These Rules were issued pursuant to the State CON Law which was passed by the 1979 Georgia General Assembly. MAG submitted comments on several portions of the Rules and we are pleased to report that at least three important sections were changed as the result of our comments.

As a result of these Rules, SHPDA has assumed total authority over the CON process in Georgia. Included in these Rules were all standards and criteria for the review of health services in Georgia. These criteria effectively overrule any standards established by the state's HSAs and place all final CON authority within SHPDA. For this reason, it is essential that the Committee concentrate considerable effort at SHPDA with regard to CON.

A third area in which SHPDA has final authority is Appropriateness Review. The Department of Health, Education, and Welfare issued final regulations for Appropriateness Review in December 1979. Under these regulations, SHPDA, in conjunction with each HSA, will determine the appropriateness of all health services in the state. Final authority for Appropriateness Review will be within SHPDA which will establish schedules for review, definitions of services, and priorities for review for all the state's HSAs. The committee met with staff of the SHPDA at its last meeting and discussed the Appropriateness Review regulations. The committee submitted for-

mal comments in March on the Appropriateness Review Work Program developed by SHPDA.

HEALTH SYSTEMS AGENCIES: In the past year, the Committee on Health Planning has worked with physicians throughout the state to increase our input into Georgia's HSAs. A statewide Health Planning Conference was held May 19, 1979 to spearhead the formation of HSA Task Forces (local groups of physicians to monitor the local HSAs). In all, 70 physicians from 29 medical societies attended this meeting. As a result of this meeting, MAG maintains a list of members interested in working with the state's HSAs and has made this list available to the HSAs. The MAG has made several nominations this past year to HSA Boards and has increased the communication with HSA staff and physician Board members through regular correspondence. Additionally, the MAG informs every county medical society president of projects reviewed by the HSA in his area every month. We have worked with physicians in all areas of the state concerning specific projects coming before their HSA Boards. The Task Forces have not yet developed according to the Minnesota Model cited at the Health Planning Conference, but the committee is succeeding in accomplishing the goals set forth by the House of Delegates. These goals are to maintain liaison with local HSAs; to provide consultation to any local MAG-sponsored Task Force; to review legislative and regulatory activities; and to provide MAG with recommendations on items concerning health planning. The result has been a substantial increase in physicians throughout the state who have been very active in HSA and SHPDA activities.

The committee has actively involved the MAG Auxiliary in monitoring the HSAs. MAG staff spoke at the summer Board meeting of the Auxiliary to encourage their participation in health planning activities. As a result of this, Irene Glucksman, President of the MAG Auxiliary in the 1979-80 year, requested that every county society Auxiliary nominate an HSA liaison to work with its respective county medical society, with the MAG staff, and with the Committee on Health Planning. We hope that the Auxiliary HSA liaisons will be able to attend HSA meetings, keep the county medical society and MAG informed of local activities within that HSA, and serve as a primary source of information for the MAG. Not all county Auxiliaries have selected an HSA liaison and we look for a considerable increase in this activity in the coming year.

The HSAs have a primary role in reviewing all federally funded public health projects in the state. MAG has been focusing its efforts with the HSAs in the area of federal funds, and the committee has specifically worked with physicians in commenting on many of these projects. We expect this activity to increase considerably in the coming year.

As previously mentioned, SHPDA has assumed most of the authority in the area of State Health Plans, CON Regulations, and Appropriateness Reviews. HSAs have the primary responsibility in the area of federal funds. For this reason, we expect our efforts with the HSAs to be concentrated in the area of federal funds to maximize our input with the HSAs.

The committee undertook a project this past year to enlist the support of a large number of physicians in the southeast Georgia HSA area. Since anyone residing in that area is eligible to vote in elections for that HSA's Board, the committee sent a mailing to all MAG members encouraging them to become involved in the upcoming election of Board members in May. We hope that all physicians in the 24 counties in the southeast Georgia area will become corporate members of the HSA and vote in this election to insure that physicians representing organized medicine have a voice on the Board of Directors of that HSA.

STATEWIDE HEALTH COORDINATING COUNCIL: The MAG submitted the names of 13 physicians as nominees for the Georgia Statewide Health Coordinating Council. The Governor requested MAG nominees, and we hope he will appoint the Statewide Health Coordinating Council in the near future. We communicated with the Governor our desire to have a council appointed to insure that SHPDA was receiving overall direction from people involved in medical care. Since its existence, SHPDA has had no governing body outside of state government to which it has been responsible. Once appointed, the Statewide Health Coordinating Council should provide MAG with the means of insuring medical input into health planning at the state level.

RECOMMENDATION

In light of the above discussion, the Committee on Health Planning makes the following recommendation:

1. That the MAG continue to monitor and influence the course of health planning and insure that physicians are involved in decisions affecting medical care.

REFERENCE COMMITTEE DISCUSSION

This report summarizes the work of this committee in monitoring the activities of health planning organizations throughout the state. The report contains a recommendation that the committee continue to monitor and influence the course of health planning to insure that physicians are involved in decisions affecting medical care.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the recommendation of the committee be adopted.

HOUSE OF DELEGATES ACTION

Adopted the recommendation of the Health Planning Committee.

THE NUTRITION COMMITTEE

Judson G. Black, M.D., Chairman

Originally formed in 1978, the Nutrition Committee has been charged to investigate current concepts in nutrition and determine their value. Initially, seven topics for study were selected. Last year, the Nutrition Committee's statement on fiber was published in the *JMAG*.

This last year, the committee has dealt primarily with the development of a position paper on carbohydrates. This paper has been somewhat slow in coming because of the wealth of material, both scientific and pseudoscientific. A position paper on carbohydrates will be released soon and published in the *JMAG*.

The committee is working on a series of articles for publication in *JMAG* on the nutritional aspects of minerals, electrolytes, and vitamins.

The other topics to be studied in the future will include (1) preservatives and carcinogens, (2) disease and diet, (3) food allergies, and (4) nutrition in the hospitalized patient.

The committee will participate in the 1980 MAG Scientific Assembly with a session on nutrition to be chaired by committee member, Dr. Elaine Feldman.

After initially a slow start, the committee will be able to disseminate more information for physicians and the public in this upcoming year than it has in the past primarily because of familiarity with nutritional literature and resources available.

RECOMMENDATION

That the Nutrition Committee be authorized to continue its investigations and development of statements on nutritional topics to MAG members and to the public.

REFERENCE COMMITTEE DISCUSSION

The report summarizes the activities of the committee over the past year, including the formulation of a statement on fiber reported in the *JMAG* and the development of a position paper on carbohydrates. It also outlines nutrition topics to be studied by the committee in the future. The report contains a recommendation that this committee be authorized to continue its investigations and to develop statements on nutritional topics for MAG members and the public.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee wishes to commend the Nutrition Committee for its work and urges adoption of the committee's recommendation.

HOUSE OF DELEGATES ACTION

Delegate O. Wytch Stubbs moved to amend the recommendation of the Nutrition Committee by addition as follows: "That the Nutrition Committee be authorized to continue its investigations and development of statements on nutritional topics to MAG members and to the public, such statements being cleared by the Board of Directors or the House of Delegates before being disseminated to the public." The recommendation of the Nutrition Committee was adopted as amended.

PEER REVIEW COMMITTEE

Walter S. Dunbar, M.D., Chairman

In 1979, the Peer Review Committee reviewed three patterns of practice cases on appeal from the medical care foundations and is in the process of reviewing three others at the time of this report.

In addition to reviewing cases, the committee reviewed the "AMA Sample Criteria Sets for Surgical Procedures." Under a contract from the Department of HEW, the AMA, in conjunction with national medical specialty societies, had coordinated a project to develop sample sets for reviewing the medical necessity and appropriateness of related surgical procedures. The committee reviewed samples of these 141 sets and developed a response for the Executive Committee to submit to the AMA. In the interest of brevity, this response was essentially negative. The AMA responded that, although they have not ceased to develop these sample sets, they are in the process of extensive revision and emphasis is being strongly made that each set will require local revision.

At the request of Blue Cross/Blue Shield of Atlanta, the Peer Review Committee reviewed extensive material relating to the utilization of biofeedback as a method of treatment. At its Jan. 31, 1980 meeting, the committee also heard presentations about the current status of biofeedback from Vaddadi Rama Rao, M.D., Associate Professor of Rehabilitation Medicine, Emory University School of Medicine, and Chief of Staff, Rehabilitation Services, Emory University and Grady Hospitals, and from Stephen J. Johnson, Ph.D., and Stanley L. Chapman, Ph.D., both of whom provide care, including biofeedback, within the Rehabilitation Department of Emory. Different members of the committee had varying ideas about the utilization of biofeedback as a medical treatment modality.

On the basis of the Peer Review Committee recommendation, the MAG Executive Committee subsequently adopted the following policy statement: "Biofeedback is an acceptable diagnostic and treatment procedure when used by a qualified individual as part of a total treatment program directed by a physician."

The committee will continue to develop educational activities relative to appropriate subjects as they arise in the peer review process.

REFERENCE COMMITTEE DISCUSSION

The report summarizes the activities of the committee over the past year, including its recommendation that the MAG adopt a policy on the utilization of biofeedback as a method of treatment.

In the course of testimony, it was brought out that the MAG Executive Committee, at its February meeting, adopted a policy that biofeedback is an acceptable diagnostic and treatment procedure when used by a qualified individual as part of a total treatment program directed by a physician. The committee heard other testimony that biofeedback is a new field, subject to misuse in patient care. Scientific proof of validity of biofeedback has yet to be accepted. The report contains no recommendation, but your Reference Committee feels that the issue is important enough to bring to the attention of the House of Delegates by means of a recommendation.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the report of the Peer Review Committee be received for information.

Mr. Speaker, your Reference Committee wishes to recommend further that "Until proper experimental support is documented, the MAG not accept biofeedback as an acceptable diagnostic and therapeutic procedure."

HOUSE OF DELEGATES ACTION

Received the report of the Peer Review Committee for information. Adopted the recommendation of the Reference Committee.



Frank L. Wilson, Jr., (R) is a study in concentration, as is James Kaufmann to his right. L. Newton Turk, III, is similarly engrossed in his work.

SPECIAL DELEGATE REPORT OF THE MAG ADVISOR TO GEORGIA CHAPTER, AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

Charles D. Hollis Jr., M.D.

The Georgia Chapter of the American Association of Medical Assistants (AAMA) recently completed its annual session and submits the following report to the parent sponsoring organization, the MAG.

At present, there are 17 chapters in Georgia, each sponsored by its local county medical society. There are 400 members of the state Association, of whom 198 have reached the status of certified medical assistants.

The goals in general for the year 1980-81 are summarized as follows:

(1) Formation of three new chapters of the Georgia State Society of Medical Assistants;
(2) Add at least two educational workshops and seminars for each chapter;
(3) Improve the relationship of the local chapter with its local county medical society by several means, including visiting with each county medical society president at least twice, providing articles about the AAMA for medical society publications, providing minutes of local meetings to medical society officers and advisors, providing general informational programs about the AAMA to local medical society meetings, and offering clerical assistance for the county medical societies for their local and regional meetings;
(4) Improve the relationship with the MAG by several means, including the publishing of at least one article about AAMA in the *JMAG,* offering clerical support to MAG or MAG staff for various meetings, having at least one scheduled conference with the MAG-appointed advisor, and keeping active communications with Ken Williams as MAG Public Relations Director;
(5) Work toward better relationships with state physician advisors by having at least one scheduled conference with all physician advisors and asking advisors to submit articles for consideration in the *Caduceus,* the state publication of the AAMA;
(6) Work toward establishing a regional meeting with medical assistants organizations from neighboring states;
(7) Encouraging at least 10 members of the state organization to serve on national committees of the AAMA;
(8) Have and support at least one member to run for national office;
(9) Have at least 30 members of the state organization attend the national convention of the AAMA;
(10) Increase the number of certified medical assistants by at least 10% each year; and
(11) Establish a speakers bureau to promote AAMA, providing speakers for such things as Health Career Days and promoting scholarship programs in local areas.

The past year under the direction of Diane Frederick, of Atlanta, has been most successful. There has been considerable strengthening of the organizational structure. There was a very well attended and very productive annual session of the AAMA in Valdosta. At that session, the educational seminar was well supported with speakers including Dr. Joe Stubbs, of Valdosta. There were also exhibits demonstrating the use of computers in physicians' offices and the use of various types of bookkeeping systems and patient flow sheets and forms for use in physician's offices. There were also demonstrations of other new equipment available. The following year under the direction of the new president, Nancy Eleam, of Rome, has already begun to take form, and it appears that this will be an equally good and productive year for the Association.

Several recommendations are being offered to the MAG House to further the support by MAG of the AAMA. These include the following recommendations:

(1) That MAG encourage its component societies to sponsor, support and supervise chapters of the Georgia Chapter of the AAMA;
(2) That MAG request a report from the state physician advisors at each annual session of MAG;
(3) That MAG sponsor an educational workshop each year for the Georgia Chapter of the AAMA;
(4) That MAG encourage its medical assistants to pursue their educational activities by presenting a certificate of merit to each assistant who achieves the status of certified medical assistant;

(5) That the MAG invite support from the AAMA in the staffing of its state and regional meetings.

REFERENCE COMMITTEE DISCUSSION

The report summarizes the activities and goals of the AAMA and contains five recommendations: (1) That MAG encourage its component societies to support and supervise chapters of the Georgia Chapter of the AAMA. (2) That MAG request a report from the state physician advisors at each Annual Session of the MAG. (3) That MAG sponsor an educational workshop each year for the Georgia Chapter of the AAMA. (4) That MAG encourage medical assistants to pursue their educational activities by presenting a certificate of merit to each assistant who becomes a Certified Medical Assistant. (5) That the MAG invite support from the AAMA in the staffing of its state and regional meetings.

Testimony brought out that this organization represents a great ally to organized medicine, and that we should take measures to insure continuing liaison with the existing 17 chapters in the state.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of this report be adopted.

Mr. Speaker, your Reference Committee foresaw some problems in having a number of additional reports made yearly to the House of Delegates, and so your Reference Committee recommends adoption of Recommendation 2 as amended in the following way: "That MAG request an annual report from the MAG advisor to the Georgia Chapter of the AAMA."

Since it is questionable whether the MAG should be solely responsible for sponsoring an educational workshop each year for medical assistants, your Reference Committee recommends adoption of Recommendation 3 with the following amended wording: "That MAG assist the Georgia Chapter of the AAMA in establishing and promoting an educational workshop each year for the Georgia Chapter of the AAMA."

Mr. Speaker, Recommendation 4 of this committee was felt to be too specific on the form of recognition of merit for medical assistants, and so your Reference Committee recommends adoption of the following amended recommendation: "That MAG encourage medical assistants to pursue their educational activities by presenting an appropriate acknowledgement to each assistant achieving the status of Certified Medical Assistant."

Mr. Speaker, your Reference Committee recommends adoption of Recommendation 5.

HOUSE OF DELEGATES ACTION

Adopted the recommendations of the Special Delegate Report as amended by the Reference Committee.

RESOLUTION 6
WELFARE OF THE PATIENT
(REFILLING OF PRESCRIPTIONS)

WHEREAS, the MAG is interested in the welfare of the patient, and

WHEREAS, the patient with a chronic disease should be under close surveillance, and

WHEREAS, most doctors write prescriptions for no more than (6) six months, and

WHEREAS, there are some pharmacists who continue to refill prescriptions without regard to the cut-off period, apparently thinking that they are helping the patient to save money by not having a doctor bill, therefore, be it,

RESOLVED, that the MAG emphasize to the pharmacy profession that to continue to fill prescriptions past the time marked on a prescription is not saving the patient money as much as endangering the patient's life, and be it further,

RESOLVED, that pharmacists comply strictly with the present statute.

REFERENCE COMMITTEE DISCUSSION

This resolution points out the difficulties encountered when pharmacists continue to refill prescriptions which do not specify the number of refills. The resolution calls upon the MAG to communicate to the pharmacy profession that continuing to fill prescriptions past the time marked is not saving the patient money as much as endangering life. It also directs that pharmacists comply strictly with the present statutes of the pharmacy laws of the State of Georgia.

Testimony brought out that the State Pharmacy Act is not clear about the time factor implied in a "p.r.n." refill order. Therefore, your Reference Committee does not feel that the resolution is practical, because it is not based on a clear definition of the issues in existing state pharmacy laws.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 6 be not adopted and that the following resolution be adopted in its place:

WHEREAS, the MAG is interested in the welfare of the patient, and

WHEREAS, the patient with a chronic disease should be under close surveillance, therefore, be it

RESOLVED, that the MAG request its members to write prescriptions for a specified length of time, and be it further

RESOLVED, that the MAG emphasize to the pharmacy profession that to continue to fill prescriptions past the time marked for the prescription is not saving the patient money as much as endangering life.

HOUSE OF DELEGATES ACTION

Adopted the substitute resolution of the Reference Committee.

RESOLUTION 10
CURRENT PROCEDURAL TERMINOLOGY (CPT) — IV

WHEREAS, the CPT-IV Procedure Code, as developed by AMA, has been accepted by the HCFA, Blue Shield-Columbus, and most major insurance carriers, and

WHEREAS, CPT-IV is the code which allows physicians to identify most specifically services rendered, thus assuring more reasonable reimbursement for those services, and

WHEREAS, CPT-IV coding of services speeds up processing time, minimizes errors, and thus assures more prompt payment to the physician, and

WHEREAS, MAG has previously indicated support for this method of coding services, now, therefore, be it

RESOLVED, that MAG commend the HCFA, Blue Shield-Columbus, and other insurance carriers for adopting CPT-IV, and, be it further

RESOLVED, that MAG recommends to Blue Cross-Blue Shield of Georgia/Atlanta and other third-party payors that they also adopt CPT-IV as a method of procedure and services coding, and be it further

RESOLVED, that MAG adopt as policy that its members identify services rendered, when submitting claims to all third-party carriers, by use of the CPT-IV service code and successor editions of current Procedural Terminology as they are developed and become available.

REFERENCE COMMITTEE DISCUSSION

The resolution points out that the CPT-IV coding system has been accepted by a number of third party payors and that it represents a major advance in the efficient processing of physicians' billing statements. The resolution calls upon the MAG to commend certain insurance carriers for adopting CPT-IV and to recommend to Blue Cross-Blue Shield of Georgia/Atlanta and other third party payors that they also adopt the CPT-IV. It recommends further the MAG adopt as policy that its members identify services rendered by use of the CPT-IV service code.

Testimony brought out that although Blue Cross-Blue Shield/Atlanta has adopted the current CPT Code, only 25% of Georgia physicians use any form of code in itemizing their services. Furthermore, only a small percentage of this group currently uses CPT-IV. Therefore, until there is more widespread use by physicians filing claims, total adoption of CPT is not financially feasible to Blue Cross-Blue Shield/Atlanta because of the estimated $250,000 cost in complete transition to its use. Currently CPT code is being manually transmitted to the computer system in use.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the RESOLVED portion of the Resolution be amended as follows:

"THEREFORE, BE IT RESOLVED that MAG commend those insurance carriers which have adopted CPT-IV, and, BE IT FURTHER

RESOLVED, that MAG recommends this method to all third party payors that they also adopt CPT as a method of procedure and services coding, and, BE IT FURTHER

RESOLVED, that MAG recommend as policy that its members use the current CPT code in identifying their services when submitting claims."

Mr. Speaker, your Reference Committee recommends adoption of the resolution as amended.

HOUSE OF DELEGATES ACTION

Adopted Resolution 10 as amended by the Reference Committee.

RESOLUTION 21
PREFERENTIAL IMMIGRATION STATUS OF PHYSICIANS

WHEREAS, inasmuch as the Health and Human Services has announced that there will be a surplus of 50,000 M.D.'s by the end of the decade, and

WHEREAS, an excess of physicians has in general a tendency to increase the cost of medical care rather than reduce it, and has a debatable effect on the quality of medical care, therefore be it,

RESOLVED, that the MAG request that the preferential immigration status of physicians be eliminated except when special skills not available in this country are demonstrated and needed where humanitarian needs must be met, and be it further,

RESOLVED, that this resolution be introduced by the MAG-AMA Delegation at the July 1980 AMA House of Delegates.

REFERENCE COMMITTEE DISCUSSION

This resolution points to the anticipated surplus of physicians and recommends that the MAG request that the preferential immigration status of physicians be eliminated except when special skills, not available in this country, are demonstrated and needed where humanitarian needs must be met. The resolution also calls upon the MAG to introduce this resolution at the July, 1980, AMA House of Delegates.

In hearing testimony, your Reference Committee was not apprised of the preferential immigration status given to physicians. However, most agreed that no special preference should be given to physician immigrants.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 21 be adopted.

HOUSE OF DELEGATES ACTION

Adopted Resolution 21.

RESOLUTION 7
INVOLVEMENT IN MEDICAL ISSUES (MEDICAL STUDENTS)

WHEREAS, involvement in medical issues is the responsibility of all physicians, and,

WHEREAS, such involvement should begin as early as possible, and,

WHEREAS, many future medical leaders exhibit leadership qualities while in medical school, therefore, be it

RESOLVED, that the MAG send as its guest one/two medical students from each medical school in the state each year to the AMA National Leadership Conference; the students to be selected jointly by the Dean and the American Medical Student Association, be it further,

RESOLVED, that each student submit a summary report suitable to publication in the *JMAG* and for distribution to all members of their respective medical schools.

REFERENCE COMMITTEE DISCUSSION

This resolution stresses the importance of getting future physicians involved in medical leadership as early as possible in their careers. It calls upon the MAG to send medical students from each medical school, yearly, to the AMA National Leadership Conference. The cost will be approximately $541.00 each. Each student would submit a summary report suitable for publication in the *JMAG*.

Testimony brought out that there are other ways to encourage participation of medical students in these activities, especially through work with MAG committees. MAG has recently appointed a number of medical students to serve on various committees. Those students who distinguish themselves in such work could be rewarded by being offered such trips to the AMA National Leadership Conference.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends adoption of the resolution with the following amended language in the first RESOLVED:

"RESOLVED, that the MAG sponsor one medical student from each medical school in the state each year to the AMA National Leadership Conference, the student to be selected jointly by the Dean and the American Medical Student Association, and from among those who have been diligent in participating in MAG committee work."

HOUSE OF DELEGATES ACTION

Adopted Resolution 7 as amended by the Reference Committee.

RESOLUTION 12
IMPLEMENTATION OF MALPRACTICE INSURANCE PROGRAM

WHEREAS, MAG is in need of a program to encourage and reward membership in MAG, and

WHEREAS, MAG wishes to establish a group malpractice insurance program limited to MAG members in good standing, and

WHEREAS, non-members of MAG have the right to negotiate with any malpractice insurance carrier they desire, therefore, be it

RESOLVED, that the Board of Directors of MAG appoint a special committee to establish such a program and submit it to the Executive Committee for their approval and implementation.

REFERENCE COMMITTEE DISCUSSION

The resolution calls upon the MAG Board of Directors to appoint a special committee to establish a group malpractice insurance program limited to MAG members and submit it to the Executive Committee for its approval and implementation.

Testimony brought out that the Board of Directors has, at its January meeting, appointed *ad hoc* committee to explore self-insurance by MAG. This committee is chaired by Dr. Charles Hollis and will have its first meeting within a month.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends adoption of Resolution 12 with the RESOLVED portion to be amended to read as follows:

"RESOLVED, that this matter be referred to the *ad hoc* committee already appointed for this purpose, that the committee request input from MAG members, and that the committee report its findings to the 1981 House of Delegates meeting."

HOUSE OF DELEGATES ACTION

Adopted Resolution 12 as amended by the Reference Committee.

RESOLUTION 16
MAG OFFICERS

RESOLVED, that no officer elected by the MAG simultaneously hold an official position with any organization or association that is concerned with decision-making for third party payment of physician's services.

REFERENCE COMMITTEE DISCUSSION

This resolution recommends that no officer elected by the MAG should simultaneously hold an official position with any organization concerned with decision-making for third party payment of physicians' services.

Testimony brought up that the basic reason for the resolution was the possibility of conflict of interest. Those opposed to the resolution stressed the service that MAG leaders had performed for organizations, such as the Georgia Medical Care Foundation, which review the appropriateness of care for third party payment.

After considerable discussion and deliberation regarding the testimony heard from both sides, it was the conclusion of the committee that there is no real conflict of interest, and that the ramifications of acceptance of this resolution could result in loss of valuable leadership to the MAG. Broader application of this principle could result in loss of leadership in component medical societies and medical leadership in the community.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 16 be not adopted.

HOUSE OF DELEGATES ACTION

Voted that Resolution 16 not be adopted.



Reference Committee F members (L-R) Dr. H. Duane Blair, Decatur, Chairman; Mr. L. B. Storey, MAG Staff; Drs. A. J. Morris, Vidalia; Clyde D. Garner, Gordon, Vice-Chairman; Stuart Prather, Jr., Augusta; and William E. Huger, Jr., Atlanta. Not shown is Dr. William R. Hardcastle, Tucker.

Report of Reference Committee F

H. DUANE BLAIR, M.D., Chairman

Chairman Blair reported to the House of Delegates that Reference Committee F had thoroughly examined and carefully considered all recommendations and reports referred to it. Reference Committee F met in Room 422, Hilton Hotel, Atlanta, Georgia, on 25 April 1980.

REPORT OF THE PRESIDENT

Earnest C. Atkins, M.D.

Only two recommendations from the Report of the President were referred to Reference Committee F, and they were Recommendation 3 and Recommendation 5. (For the complete text of the Annual Report of the President see Report of Reference Committee A.)

Recommendation #3: states the print shop has been a financial disaster. Neither the majority of our MAG members nor the staff is interested in supporting it. Direct the MAG Services, Inc., Board of Directors to dispose of it in a manner that will be most beneficial to MAG.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Recommendation #3 of the Report of the President be adopted.

HOUSE OF DELEGATES ACTION

Adopted Recommendation 3 of the Report of the President as submitted.

Recommendation #5 states: Recommend no dues increase until our liquid assets, including the land acquisition fund, are below $500,000, and allow the spending of these reserves to be done with the recommendation of the Finance Committee and the approval of the Board of Directors.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Recommendation #5 of the Report of the President be adopted with the following amendment by deletion and substitution: "There should be no dues increase for MAG members until the liquid, unrestricted funds of MAG are reduced to one-half (½) of the amount budgeted for expenses in each year's Association Budget as approved by the House of Delegates, and that these funds be spent only by recommendation of the Finance Committee and Board of Directors."

HOUSE OF DELEGATES ACTION

Adopted Recommendation #5 of the Report of the President as amended by the Reference Committee.

REPORT OF THE TREASURER

James H. Sullivan, M.D., Treasurer

It has been a pleasure to serve in the capacity of Treasurer of the MAG. I truly appreciate the able assistance of Mr. L. B. Storey, Mrs. Jane Scott, the Finance Committee, the Executive Committee, the Board of Directors, and the House of Delegates.

If all budget requests were granted, we would no doubt have to raise the dues of MAG. Since we cannot grant 100% of all requests, it becomes the responsibility of the Finance Committee, in order to present a balanced budget to the Board of Directors, to make an evaluation of each request. The responsibility for a balanced budget was mandated by the House of Delegates in 1976.

This year the staff of MAG has done a remarkable job in getting their committee chairmen to reduce their budgets realistically. This is a prudent move because these are most uncertain times, with inflation proceeding at an alarming rate, a recession present, and a possible depression over the next hill. We are earning the highest rate of interest available for our 30-day and 3-month Certificates of Deposit, which is over 17% at the present time. We are in excellent financial condition.

We have the finest staff that I have been associated with at MAG. With our restructuring of Executive Staff, recommended raises and good fringe benefits, we can look forward to improved morale and efficiency from our staff.

The Sinking Fund for land acquisition will again be increased 31 May 1980. The Board of Directors will make a recommendation regarding the Sinking Fund, staying at our present location, and planning to enclose our present covered parking area for use of needed office space.

GaMPAC is a very important and viable part of our organization. Its contribution to the political process on behalf of MAG and its individual members has been noteworthy. Each of us at MAG owes a tremendous debt to the hard workers in GaMPAC for their political activism.

The annual rise in inflation approaching 18% and the periodic increases in Social Security taxes make effective budgeting and fiscal management a difficult task. In spite of these obstacles, MAG remains in a strong financial position.

Our Xerox machine will pay for itself in 3 more years and was certainly a wise investment.

The Information Systems Department (Computer) under the capable leadership of Mr. Bob Brown continues to provide MAG needed services at a favorable rate. It also provides services to the Georgia Medical Care Foundation in a way that maximizes confidentiality of sensitive information. The decision by the House of Delegates, after recommendation by the Treasurer, Finance Committee, Executive Committee, and Board of Directors, to purchase the computer was indeed a wise decision.

In this past year, we discussed moving to a leased building to coordinate our in-house staff functions. Due to the ultimate decision by the Board of Directors and the future construction of a Marta Station close by the MAG property, it appears to be a wise decision to stay in our present location.

One failure in past years has been recruitment of new members to MAG. We have at present approximately 4,180 dues paying members and approximately 4,900 total MAG members, of a total of 6,300 that are practicing in the State of Georgia and are eligible for membership. By setting our goal to attract all of those ethically acceptable, we could add to our treasury and obviate the need of a dues increase for some years. Based on last years membership figures, if we had an additional 276 members join the AMA, we would get a fifth Delegate and Alternate Delegate to the AMA House of Delegates.

Regarding the interns, residents, and senior medical students, we have supported these groups financially to attend their own national meetings as well as our MAG House of Delegates meetings. These medical students really want and need the guidance of our Association members and should be represented on committees. They are not the radical students of 5 or 10 years ago.

We have an excellent *Newsletter*, supported in part by Roche Laboratories, that does a good job in disseminating information to the membership.



(L-R): Drs. Milton Frank, Atlanta, and E. Capers Palmer, Jr., LaGrange take a break between committee reports.

The incoming WATS Line, which is used frequently, is an outstanding benefit to our members.

The *JMAG* is an award winning publication. Nonetheless of late, it has run deficits of approximately $50,000 annually.

The Scientific Assembly has again been a success at offering Continuing Medical Education to the membership. In addition to the Scientific Assembly, MAG has sponsored the PEP Seminar, Physician Recruitment, Cost Awareness Conference, Pre-Practice Seminar, Practice Management Workshops, and the Public Relations Workshop.

We have carried on one of the finest lobbying activities, both state and federal, of any state medical association.

MAG is such an interesting, viable, and active organization that I could continue this report for 10 more pages. However, I would like to conclude at this point and make the following recommendation.

RECOMMENDATION

(1) I would like to recommend that the Board of Directors and the House of Delegates form a committee to study MAG's *Journal* with ideas for income, as we continually run approximately $50,000 a year in the red. However, this only amounts to $62 per year, per dues paying member.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Recommendation #1 of the Report of the Treasurer be adopted.

HOUSE OF DELEGATES ACTION

Adopted Recommendation #1 of the Annual Report of the Treasurer as submitted.



Jack A. Raines, MAG's new Chairman of the Board of Directors, listens to some points of interests being described by W. Dan Jordan, Atlanta.

BOARD OF DIRECTORS — BUDGET 1980-1981

Joe C. Stubbs, M.D., Chairman

	Proposed Budget 1980-1981
INCOME:	
Dues Collection — 4,180 MD's	$ 940,500
Interest & AMA Refund	75,000
Journal Advertising	55,000
Newsletter (Roche)	3,000
Rental Income	49,500
Journal Subscriptions	5,000
Computer Income	247,718
TOTAL INCOME	$1,375,718
EXPENSES:	
Retainers, Legal Costs	48,600
Journal	111,764
Membership & Public Services	119,133
Committees	173,150
Salaries, Fringe Benefits, Payroll Tax	452,231
Management Services	32,650
Association Activities	45,480
Building Costs	153,531
Computer Expense	220,582
TOTAL EXPENSES	$1,357,121
Excess Income over Expense	18,597
TOTAL EXPENSES	$1,375,718

LEGAL COSTS AND RETAINERS:	
Legal	$35,000
Insurance Actuary	10,000
Other (Franklin)	3,600
TOTAL	$48,600

	Proposed Budget 1980-1981
JOURNAL:	
Salaries	$26,257
Fringe Benefits	3,733
Payroll Taxes	1,687
Printing & Paper Costs	60,000
Photo Processing	450
Advertising Commissions	9,000
Advertising Promotion	1,000
Postage & Copyright	4,400
Subscriptions & Dues	262
Clipping Service	350
Artwork	3,500
Mailing Labels	450
Travel	675
TOTAL	$111,764

MEMBERSHIP AND PUBLIC SERVICES	
WATS Line	$ 4,200
Telephone	21,900
Postage	20,000
Roster	8,000
Travel — President	5,500
Travel — President-Elect	3,200
Travel — Past-President	3,200
AMA Delegate Costs:	
Caucus Breakfasts	1,300
MAG Headquarters Suite	2,500
Travel — AMA Delegates & Alternates	15,896
Travel — Officers	5,012
Southeastern Coalition Assessment	800
Southeastern Coalition Suite	2,000
Interprofessional Council	125
AMSA Travel to MAG Annual Session	300
AMSA Travel Cost	650
Travel — Staff	23,000
State Medical Education Luncheon	250
AMA Leadership Conference (2 MD's)	1,300
TOTAL	$119,133

COMMITTEES:	
Access to Health Care	$ 4,040
Annual Session	10,895
Auxiliary to MAG — Health Careers	19,280
Disabled Doctors Program	75,000
GaMPAC	8,700
Health Planning	500
Liaison — Dept. of Human Resources	600
Education	3,901
Legislation & Bulletin	13,594
Medical Aspects of Sports	500
Composite Board of Medical Examiners	400
Nutrition	500
Physician-Lawyer Liaison	1,250

	Proposed Budget 1980-1981
Prison Health Care	4,365
Professional Liability Insurance	550
Public Relations	11,450
Scientific Assembly	8,420
Newsletter	4,500
Allied Health	5
MAG Foundation	4,700
TOTAL	$173,150

MAG STAFF SALARIES, FRINGES & PAYROLL TAX:

Executive Staff	212,407
Fringe Benefits	26,662
Payroll Tax	12,206
TOTAL EXECUTIVE STAFF	$251,275
SUPPORT STAFF	78,650
Fringe Benefits	14,479
Payroll Tax	4,755
TOTAL SUPPORT STAFF	$97,884
SECRETARIAL, MEMBERSHIP, ETC.	86,381
Fringe Benefits	10,394
Payroll Tax	6,297
TOTAL SECRETARIAL, MEMBERSHIP STAFF	$103,072
TOTAL ALL SALARIES, FRINGE & TAX	$452,231

MANAGEMENT SERVICES:

Dues and Subscriptions	$ 1,750
Data Base Maintenance	5,000
Audit	5,000
Office Supplies	9,500
Sundry — Flowers, etc.	300
Equipment Purchases	6,500
Xerox Maintenance	1,800
Payroll — Computer	1,200
Retirement Trust Fee	1,000
Labels — Computer	600
TOTAL	$32,650

ASSOCIATION ACTIVITIES:

Executive Committee Contingent	$ 5,000
Executive Committee Discretionary	5,000
Executive Committee Travel	5,000
Car Allowance	3,480
Meetings	3,000
President's Contingency	24,000
TOTAL	$45,480



H. Duane Blair, M.D., Chairman of Reference Committee F, reports to the House.

	Proposed Budget 1980-1981
BUILDING EXPENSE:	
Maintenance:	
Building	$ 7,000
Equipment	4,800
Taxes — Assets	14,200
Janitorial Services	11,300
Utilities	21,000
Building and Travel Insurance	5,500
Depreciation:	
Building	15,500
Equipment	13,435
Sinking Fund — Land Acquisition	47,000
Interest on Mortgage	13,796
TOTAL	$153,531

COMPUTER EXPENSES:

Personnel	$ 97,892
Fringe Benefits	11,282
Payroll Tax	6,583
Travel	2,500
Dues and Subscriptions	2,000
Consulting Fees	2,500
Recruitment	250
Equipment Rental	29,640
Maintenance	14,300
Data Communication	1,200
Service Subcontracts	9,600
Supplies — Durable	2,200
Supplies — Expendable	7,500
Softwear-Documentation-Fees	2,500
Equipment Purchase	14,180
Depreciation	10,800
Office Operation — Telephone, Supplies, Postage, etc.	5,655
TOTAL COMPUTER EXPENSE	$220,582



Michel Glucksman, M.D., makes another point on the floor of the House.

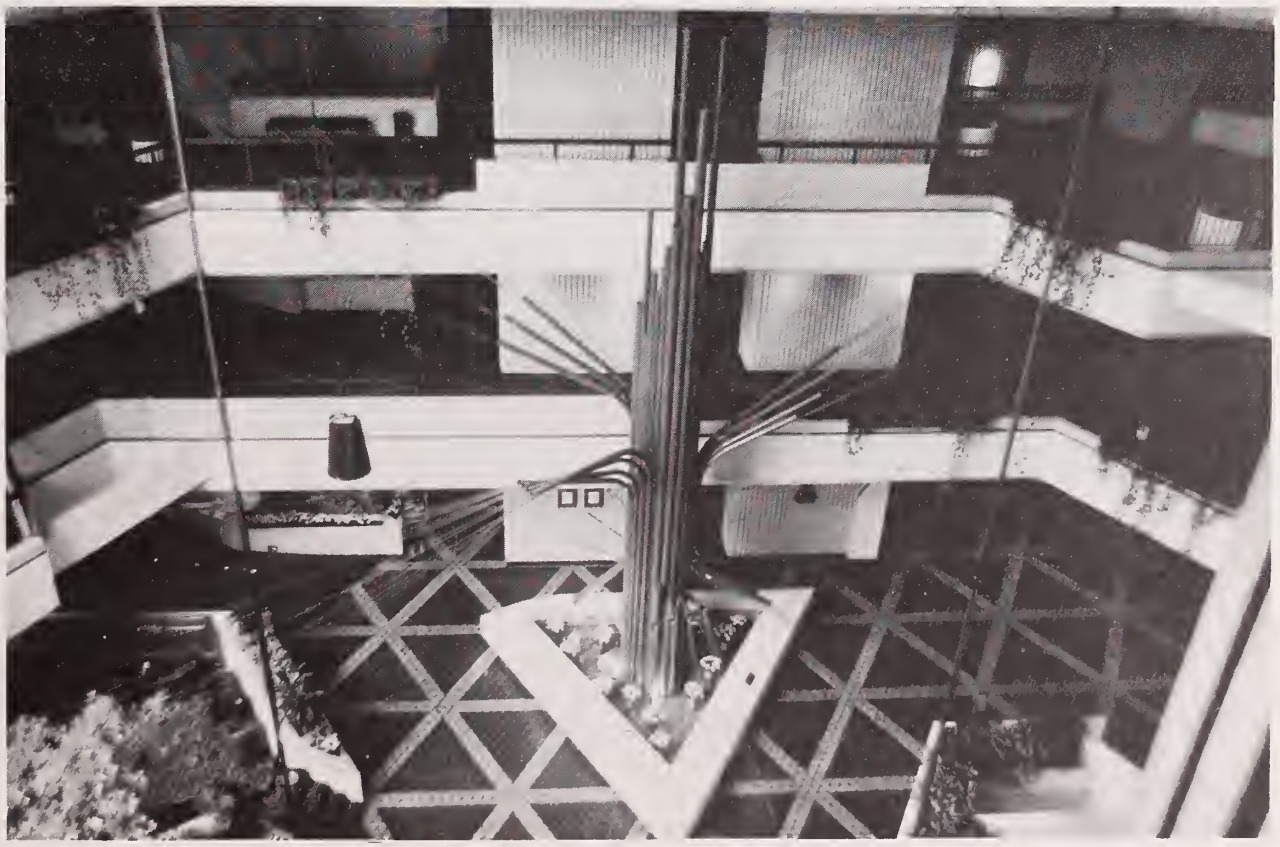
REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the Association budget be adopted as presented, with the following amendment: "That item listed as Sinking Fund — Land Acquisition, page 6, be changed to, Building and Renovations, and that the budgeted amount be spent only on approval of the Board of Directors for Building and Renovations. Your Reference Committee further recommends changing the funds now in Sinking Fund — Land Acquisition to Building and Renovations Fund. These funds are to be spent only on approval of the Board of Directors for Building and Renovations."

HOUSE OF DELEGATES ACTION

Adopted the 1980-1981 Budget for the MAG as amended by the Reference Committee.

Mr. Speaker, this concludes the report of Reference Committee F. Mr. Speaker, all the members of Reference Committee F, H. Duane Blair, Chairman, Decatur; Cyler D. Garner, Vice-Chairman, Gordon; William E. Huger Jr., Atlanta; Stuart H. Prather Jr., Augusta; William R. Hardcastle, Tucker; and A. J. Morris, Vidalia; would like to express their appreciation to everyone who took part in our discussions and deliberations, as well as the usual excellent staff assistance of Mr. L. B. Storey.



An inside view of the elegant Atlanta Hilton.

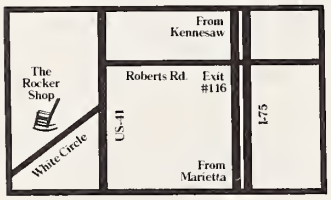
ROCKING THE NATION FOR OVER 100 YEARS...THE ONE AND ONLY BRUMBY ROCKER, ONLY AT THE ROCKER SHOP.

Few things have withstood the test of time as the Brumby Rocker. From it's early southern heritage, to today's White House, the Brumby has established a reputation as the world's finest handcrafted rocker. The moment production begins, to the moment we sell it to you, the Brumby is treated with the finest skill and care. The same skill and care used over 100 years ago when Brumbys were first made in 1875.

A Brumby Rocker is an investment in a future family heirloom. In fine homes throughout the country it has become a part of the family, rocking generations of children and a source of relaxation for all.

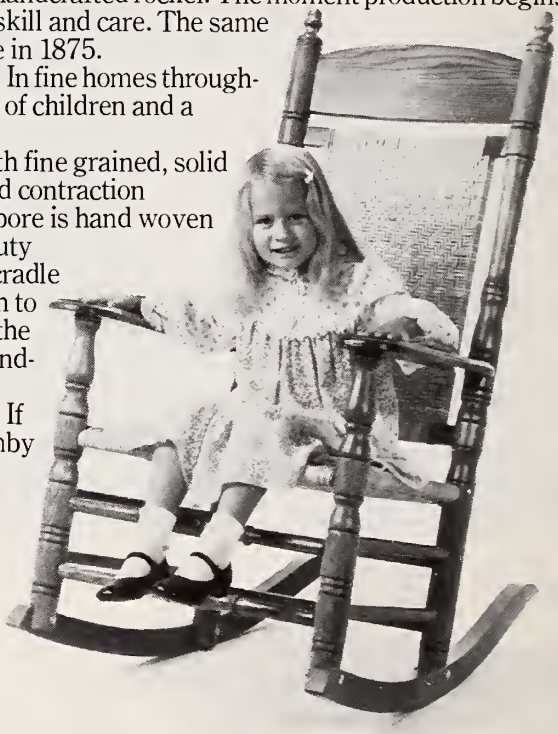
What gives the Brumby this enduring popularity? It begins with fine grained, solid oak which is half air dried and half kiln dried for natural expansion and contraction which helps prevent warping or bending. "Blue Tie" cane from Singapore is hand woven on both sides of the seat and back for comfortable cushioning and beauty from every angle. The steam bent back posts are curved to naturally cradle your back. The extra wide runners are designed with a slight rear arch to give an even rock and help prevent tipping. The man-size arms, with the original Brumby seal, let you rest your elbows comfortably. All are hand-sanded to a warm finish that accentuates the fine grained wood.

Good things are hard to find, but always well worth the search. If the Rocker Shop is a little out of your way, we'll gladly ship your Brumby Rocker anywhere. Major credit cards accepted.



The Rocker Shop of Marietta, Georgia

1421 White Circle, N.W. • P.O. Box 12
Marietta, Georgia 30061 • (404) 427-2618



Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

Auxiliary Highlights

Awards Received



Mrs. George M. Chastain (L) from Dougherty County and Mrs. George R. Jones from DeKalb County received Membership Awards for increasing their membership by 10%.



Mrs. George M. Chastain, Dougherty County, (L), Mrs. James W. Scott, Tift County, and Mrs. Jimmy R. Asbell, Bibb County, pose with their 1980 Safety Awards at the 1980 Annual Meeting of the Auxiliary to the MAG.



(Back row, with head half showing): Mrs. Mark Brown, Richmond County; (Front row L-R): Mrs. Earl Haltiwanger, M.A.A.; Mrs. Robert L. Raitz, Whitfield-Murray; Mrs. Jose Roberto Flores, Baldwin; Mrs. Myron M. Katz, Clayton-Fayette; Mrs. Robert M. Patton, Muscogee; Mrs. Kenneth A. Hoose, Jr., DeKalb; Mrs. Robert M. Cates, Floyd-Polk-Chattooga; Mrs. George M. Chastain, Dougherty; Mrs. Phil Astin, Carroll-Haralson; Mrs. Jimmy Asbell, Bibb, display their Scrapbook Awards.



(L-R) Mrs. Milton Satcher (Ann), the new President of the Auxiliary to the MAG, Mrs. Ben Johnson, Sr., President of the Auxiliary to the American Medical Association, and Mrs. Charles Prater, President-Elect of the Southern Medical Association Auxiliary.



More recipients of the 1980 Achievement Awards are (L-R) Mrs. Robert L. Raitz, Whitfield-Murray; Mrs. Jose Roberto Flores, Baldwin; Mrs. George M. Chastain, Dougherty; Mrs. Robert M. Patton, Muscogee; Mrs. James W. Scott, Tift.



Mrs. James W. Scott from Tift (L) and Mrs. Kenneth A. Hoose, Jr., from DeKalb, receive certificates for their respective county's contributions to the AMA-ERF.



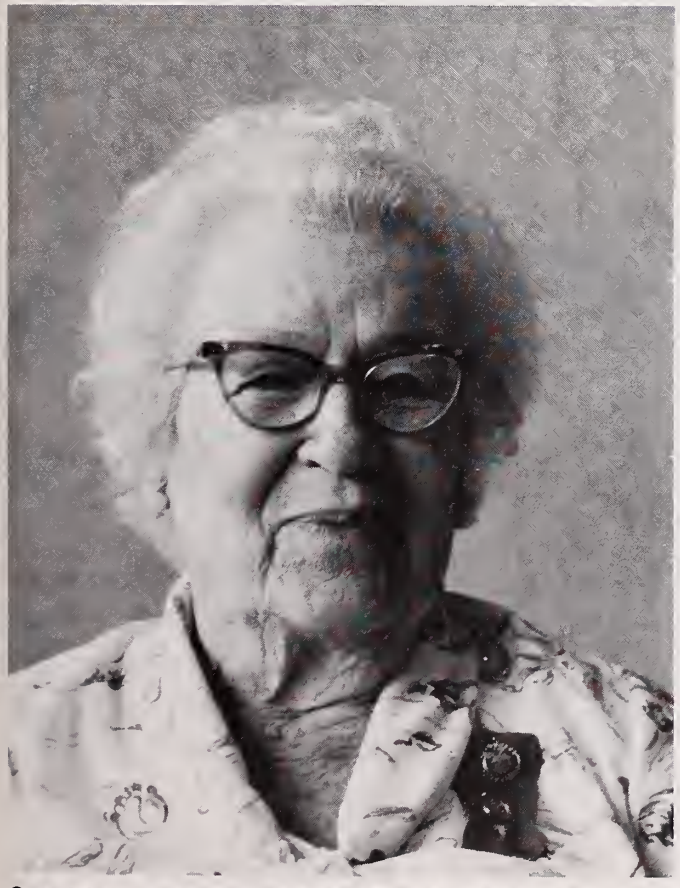
Receiving awards for their county's outstanding projects designed to meet community needs on Doctors' Day are (L-R) Mrs. Mark Brown, Richmond; Mrs. Robert M. Cates, Floyd-Polk-Chattooga; and Mrs. James W. Scott, Tift.

New Officers Sworn In



Mrs. A. Worth Hobby (L) installed this year's new officers. They are (below L-R): President, Mrs. Milton B. Satcher; President-Elect, Mrs. Perry M. White; First Vice-President, Mrs. George R. Jones; Second Vice-President, Mrs. David C. Thibodeaux; Third Vice-President, Mrs. Thomas W. Marks; Treasurer, Mrs. W. Jack Smith; Historian, Mrs. Charles W. Walden; Corresponding Secretary, Mrs. Emmerich Von Haam; Parliamentarian, Mrs. Shelley C. Davis. (Not shown is Recording Secretary, Mrs. Sammie D. Dixon.)





One of the "great ladies" of the Auxiliary to the MAG, Mrs. Ralph H. Chaney, Sr., of Augusta is also one of the most beloved. President of the A-MAG from 1937 to 1938, she is the oldest living active past-president, attending every meeting of the Executive Board and every Annual Convention.



Attending the Past-Presidents' Brunch were (L) Mrs. Hayward S. Phillips from Stone Mountain, and Mrs. Luther H. Wolff from Columbus.



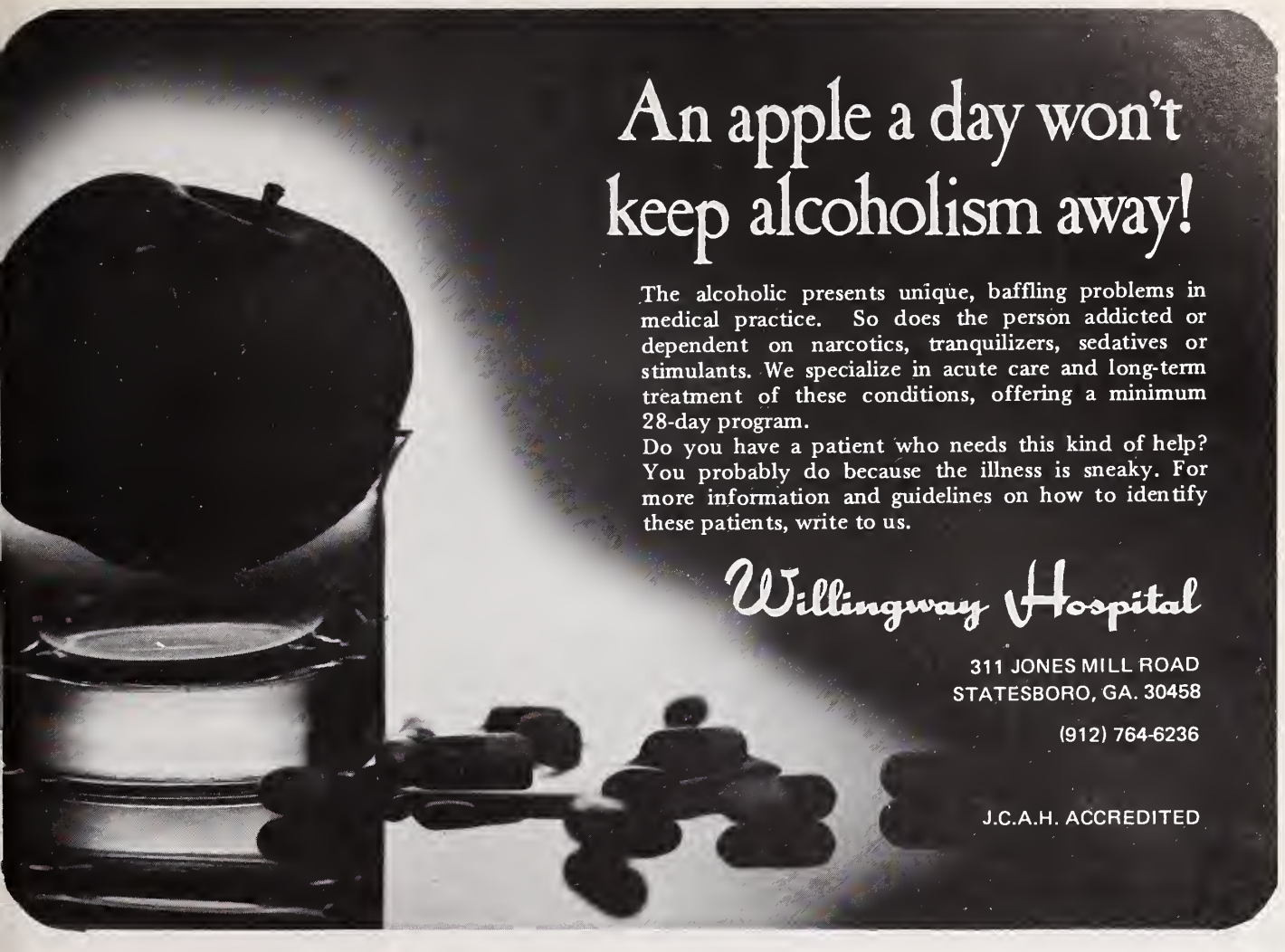
The friendships formed among the past presidents are some of the richest and best. Attending here are (L-R) Mrs. John G. Bates, Mrs. A. Worth Hobby, Mrs. Shelley C. Davis, Mrs. Milton F. Bryant, and Mrs. George Harrison.



Mrs. Milton Satcher (Ann), A-MAG's new President receives a bouquet from the luncheon speaker, Mr. Bjourn Secher.



Attending the Past-Presidents' Brunch were (Front row L-R) Mrs. Michel A. Glucksman, Immediate Past-President; Mrs. Robert S. McMichael, and Mrs. Ralph H. Chaney, Sr.; (Second row L-R): Mrs. A. Worth Hobby, Mrs. E. W. Waldemayer, Mrs. George Harrison, Mrs. Shelley C. Davis, Mrs. Hayward S. Phillips, and Mrs. Walker S. Curtis; (Third row L-R): Mrs. John G. Bates, Mrs. Milton F. Bryant, Mrs. Luther H. Wolff, and Mrs. John Leslie.



I am willing to state that we are on the threshold of decadence, that the so-called modern individualism is about to turn the realistic, and just developing, concept of the individual into a cult which accepts the most ruthless egotism, accepts success without considering the ways and means by which it has been attained, which absolves the guilty of responsibility for the crime, and manipulates punishment and the conditions for which it may be applied. Would it be surprising if society, drunk from triumphant delusions of freedom, would find itself face to face with a reaction which, spurred on by moral indignation, would demand intervention by government, restriction and rigid authority?

Baron Karl von Rokitansky (1804-1878)
Valedictory address, 1857 (tr. by Max Samter)



Incoming President of the Alumni of the Medical College of Georgia, David A. Wells, Dalton, accepts the symbolic gavel from Calvin Jackson.

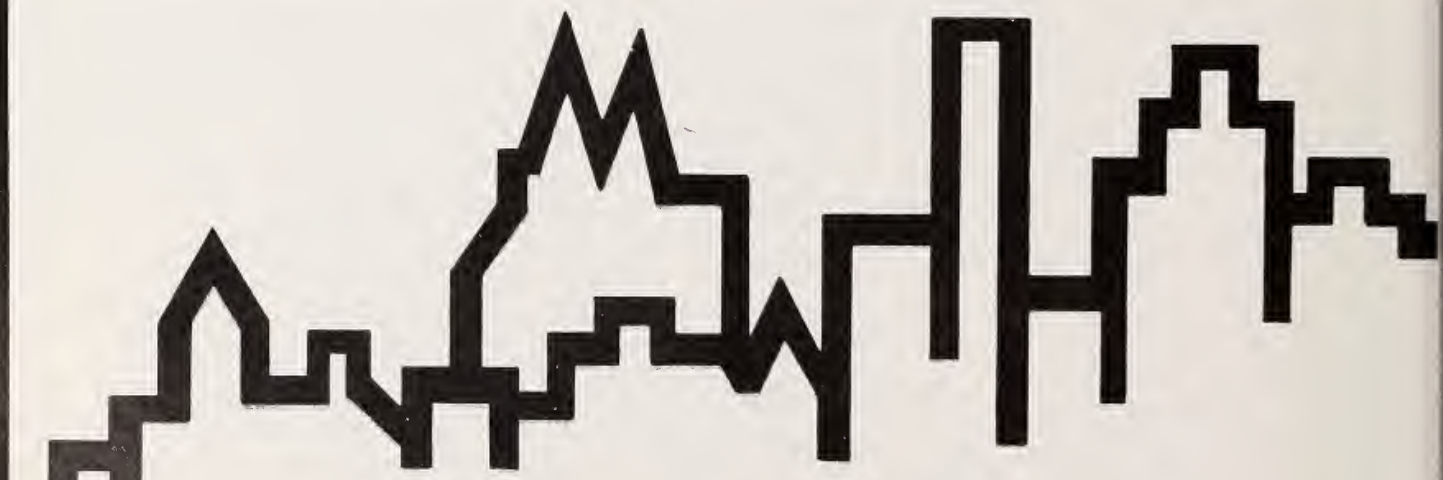




Alumni of the Medical College of Georgia enjoy a dinner in their honor at the Annual Business Meeting.

Psychiatric Institute of Atlanta

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151



A potpourri of Delegates, including Joe Bailey (front left) from the MCG in Augusta.

Third Session, House of Delegates
Sunday, April 27

The Third Session of the MAG House of Delegates was called to order by Speaker L. C. Buchanan at 9:15 AM, Sunday, April 27, in the Grand Ballroom of the Atlanta Hilton Hotel.

The Reverend Allison Williams, Pastor of the Trinity Presbyterian Church of Atlanta, gave the Invocation.

Speaker Buchanan then presented H. Hilt Hammett Jr., MAG's President-Elect. Dr. Hammett spoke to the House giving his general view of the MAG and its place in the preservation and advancement of organized medicine in Georgia.

Speaker Buchanan asked for a report on attendance from the Credentials Committee, and it was duly reported that there were 177 Delegates registered and present in the House, and, accordingly, a quorum did exist.

REFERENCE COMMITTEE REPORTS

Speaker Buchanan called for reports from the Reference Committee chairmen. The order of presentation of the Reference Committee reports was Reference Committee B, Reference Committee C, and consideration of that portion of Reference Committee A pertaining to amendments to the Bylaws. (For clarity, however, all of the Report of Reference Committee A is printed together in the Second Session section.)

ANNOUNCEMENT OF ELECTION RESULTS

The Speaker announced the results of the elections as follows:

President-Elect, L. Newton Turk, III
Second Vice-President, William C. Collins
Speaker of the House, Jack F. Menendez
Vice-Speaker of the House, James A. Kaufmann
AMA Delegate, Harrison L. Rogers, Jr.
AMA Delegate, J. Daniel Bateman
AMA Alternate Delegate, W. W. Moore
AMA Alternate Delegate, H. Hilt Hammett, Jr.
Sixth District Director, James M. Skinner
Sixth District Alternate Director, Norman P. Garner

There being no further business to come before the House of Delegates the House was adjourned at 1:10 PM.

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Report of Reference Committee B

JACK A. RAINES, M.D., Chairman

Mr. Speaker and members of the House of Delegates, Reference Committee B has thoroughly examined and carefully considered all items referred to it and submits the following report:



Drs. Arthur P. Merrill, Jr., Atlanta; Jack A. Raines, Columbus, Chairman; D. Morton Boyette, Albany, and John P. Heard, Decatur, Vice-Chairman, of Reference Committee B listen to discussion on HMOs.

COMMITTEE ON PHYSICIAN'S ASSISTANTS

William J. Rawls, M.D., Chairman

The Committee on Physician's Assistants (PAs) has continued to be active, meeting three times in the past year. In addition, I as chairman attended two meetings of the Composite State Board of Medical Examiners when the subject of PAs was the principal topic.

The 1979 MAG House of Delegates voted to recommend to those involved in training and certifying PAs in Georgia that, until the need for more PAs is documented, the training and certification of PAs in Georgia be terminated as the current training cycles end. To implement this recommendation, the House adopted a further recommendation that the Executive Committee appoint a special delegation to urge the discontinuation of the PA programs to the appropriate officials involved in training and certifying PAs. In May, 1979, the Executive Committee appointed an *ad hoc* committee, with myself as chairman, to develop a position on the specific direction of the House and a fact sheet on the need of continuing training programs for PAs, and to present its recommendations to the Executive Committee prior to making any contact with the medical schools. The *ad hoc* committee held a conference call meeting in June and subsequently drew up and approved the following document:

Position Statement on Physician's Assistants

The MAG opposes the further training and certification of physician's assistants (PAs) in Georgia unless a need for them can be clearly demonstrated.

The concept of the PA was fathered by Dr. Eugene Stead of Duke University, who believed that much of the service provided by primary care physicians could be rendered by persons less extensively trained in biomedical science and patho-physiology of disease. In 1965, Dr. Stead started the first PA training program at Duke, with admission of four ex-military corpsmen, and in fact, some of the original impetus for formal PA programs stemmed from the desire to better use the capabilities of returning military personnel who had acquired training and skills in health care.[1] The field has grown to the extent that there are now nearly 60 programs nationwide from which some 1,500 PAs are graduated annually. An HEW study on health manpower projects that at the present rate the number of PAs will increase from 2,540 in 1975 to 27,700 in 1990.[2] Beginning with the first graduating classes in 1973, the two PA programs in Georgia have trained a total of 341 PAs, and 64 new students are accepted into the programs each year. The total number of PAs certified to practice in Georgia as of August, 1979, is 338.

1. Sweeny, DR Jr. Report of the council on medical services: functions and reimbursement of new health practitioners. AMA Delegates Handbook, June 1977, Report L, p. 2.

2. Tarlov AR, et al. Interim report of the graduate medical education National Advisory Committee to the Secretary, Department of Health, Education, and Welfare. DHEW Publication No. 79-633 (April, 1979), p. 234.

The early growth of the PA training programs was fostered by the generally held opinion that more health manpower of all kinds was needed, especially in rural and medically underserved areas. In a 1972 article in the *Journal of the American Medical Association,* for instance, Malcolm Todd and Donald Foy suggested that "a preferred approach" to the problem of the medically underserved would be to "encourage use of new types of allied health personnel *where their need has been adequately demonstrated.*"[3] (Emphasis added) The federal government supported this idea by providing a major portion of the funding for PA training programs, while at the same time maintaining the level of funding for the training of medical students. Each of the PA programs in Georgia still receives federal funds of at least $200,000 annually. Recently, however, the assessment of need has changed, and the federal government is now attempting to reduce and eventually eliminate capitation grants to medical schools.[4] It is reasonable to assume that federal funding for PA programs will be similarly affected.

The federal government's change of perception about the need for medical manpower was most forcefully iterated by the Secretary of HEW, addressing a meeting of the Association of American Medical Colleges in October, 1978: "Overall we face in the next decade an oversupply of doctors; unless we change direction, we will seriously aggravate the oversupply by the end of this century."[5] In a recent interview the president of the AAMC concurred with this assessment by predicting that the nation's primary care requirements would probably be met by 1985, without any change in the system.[6] A similar conclusion is reached in an important new study of primary care delivered by specialists: the primary-physician manpower deficit should be almost eliminated by the mid-1980's.[7]

A problem of distribution will probably persist even with a general oversupply of medical manpower, but it is incorrect to view the training of more PAs as an answer to the problem. Georgia's Physician's Assistant Act stipulates that every PA must be employed and closely supervised by a physician. Medically underserved communities must therefore recruit physicians before they can utilize PAs, and many communities do not have the resources and facilities to attract physicians. Although one of the principal stated purposes of PA training programs is to increase primary care services in rural areas, the programs in Georgia do not appear to be accomplishing this to any great extent. For example, only 20 out of the 79 graduates of the PA program at Emory University who are practicing in Georgia are practicing in rural areas. This statistic led the North Central Georgia Health Systems Agency, in its 1979 review of the Emory program, to question whether or not federal dollars should be spent for a program that may not be meeting objectives of national health priorities.

If current predictions about the oversupply of medical manpower are borne out, PAs will almost certainly experience increasing difficulties in finding employment. It is incumbent upon the directors of PA programs to give serious consideration to practical aspects of the future and to question whether the continued acceptance of new PA students is fair to the students themselves. The issue is an important one to the MAG — important enough for it to recommend that the PA programs accept no new classes without documenting a need for more PAs in Georgia.

The MAG Board of Directors, at its September meeting, discussed the position statement, and I communicated through MAG's Executive Director my recommendation that the document be referred to the 1980 House of Delegates. My feeling was that any statement on this subject should be very carefully drawn and scrutinized in detail by the House before it is presented to the medical schools. The Board voted to adopt the statement as MAG policy with the understanding that the wishes of the House would be carried out using this statement.

In October, I met in person with the Executive Committee to discuss the previous month's action of the Board, and the Executive Committee passed a motion that the position statement be referred to the Committee on PAs for inclusion in its annual report to the House, and that the statement also be distributed to all county medical societies requesting action as soon as possible.

Our committee has discussed at length the 1979 House action and position statement on PAs, and it has agreed on the first recommendation found at the end of this report.

Another recommendation adopted by the 1979 House of Delegates was that the Committee on PAs continue its efforts in developing guidelines which might, with the approval of the Executive Committee, assist the Composite State Board of Medical Examiners in its task of developing and redefining rules and regulations for PAs that are in agreement with the recommendations of the House.

For the past 2 years, the Committee on PAs has been convinced that the existing Rules and Regulations for PAs are not clear on the specifics of supervision of the PA. As you will recall, we brought to the House last year a document entitled, "Proposed Rules and Regulations Regarding Performance of Medical Acts by Physician's Assistants." This document represented the committee's suggestions for clarifying the supervision of PAs in office, hospital, emergency room, and nursing home settings. In the past year, our committee revised this document so as to contain and be consistent with the House's definition of supervision of the PA as "being in the physical presence

3. Todd MC, Foy DF. Current status of the physician's assistant and related issues. JAMA 1972; 220:1714.

4. Ruhe, CHW. 1984: nightmare or utopia for medical education? JMAG 1979; 68:21.

5. Califano JA Jr. The government-medical education partnership. J Med Ed 1979; 54:19.

6. See *American Medical News,* July 20, 1979, p. 9.

7. Aiken LH. "The Contribution of specialists to the delivery of primary care," N Engl Med J, 1979; 300:1369.

of the responsible physician or his covering physician designee on a daily basis and that all decisions regarding diagnosis and treatment must be at the direct physical or phone contact with said responsible physician or his covering physician designee.'' In January, the Executive Committee gave me permission to use our committee's revised guidelines for PAs as a kind of ''working paper'' in communicating with the State Board as it attempts to revise the Rules and Regulations for PAs.

The State Board has in fact undertaken the task of revising the Rules and Regulations for PAs. After some initial difficulties brought about by lack of communication between our committee and the Board, the Board has allowed me to attend its meetings in which it discusses PAs and to make suggestions about regulations for PAs. Our committee's second recommendation reflects the ongoing nature of this work.

A new area of concern to the committee this year has been the specialty PA. We have observed an increasing number of highly-trained technicians in specialties, such as surgery, anesthesiology, and respiratory therapy, who have sought and obtained certification from the Composite State Board of Medical Examiners as PAs. Up to this time our committee has addressed itself principally to primary care or ''type A'' PAs, but we see a need to devote our attention to a study of specialty or ''type B'' PAs. The specialty PA may in fact present a greater problem than the primary care PA, since responsibility for supervision is less clear, and there is doubt as to whether the present Rules and Regulations adequately control the activities of specialty PAs. Our third recommendation expresses this concern.

Although the Composite State Board is the appropriate body to receive and act upon complaints about abuses of PAs, our committee has continued to monitor the activities of PAs and their employing physicians. We have received only a minimal number of reports about possible abuses during the past year.

RECOMMENDATIONS

(1) That the MAG Executive Committee appoint a delegation from its own members to meet with the appropriate higher officials of the schools training PAs to urge discontinuation of the PA programs, until the need for more PAs can be documented. This delegation should base its position on the ''MAG Position Statement on Physician's Assistants'' previously adopted by the MAG Board of Directors.

(2) That the Committee on PAs continue to request representation at meetings of the Composite State Board of Medical Examiners when PAs are the principal topic of discussion, for the purpose of exchange of information and appropriate input into revision of the Rules and Regulations for PAs.

(3) That the Committee on PAs study the development, training, and certification of the specialty PA to insure that there are adequate controls on this type of PA; and that a report be brought back to the 1981 House of Delegates.

(4) That the Committee on PAs continue to monitor the activities of PAs and their employing physicians to insure that the utilization of PAs does not lead to abuses in medical care which might be harmful to patients.



Jack A. Raines, M.D., Columbus, MAG's new Chairman of the Board of Directors.

REFERENCE COMMITTEE DISCUSSION

Mr. Speaker, your Reference Committee commends Dr. Rawls and the members of his committee for an excellent, precise report. The report contains a summary of the entire question of PAs with appropriate bibliography. The report also contains a position statement which has been adopted and reaffirmed by the Board of Directors. Your committee heard no testimony which suggested that any changes should be made in the historical survey or in the previously adopted position statement.

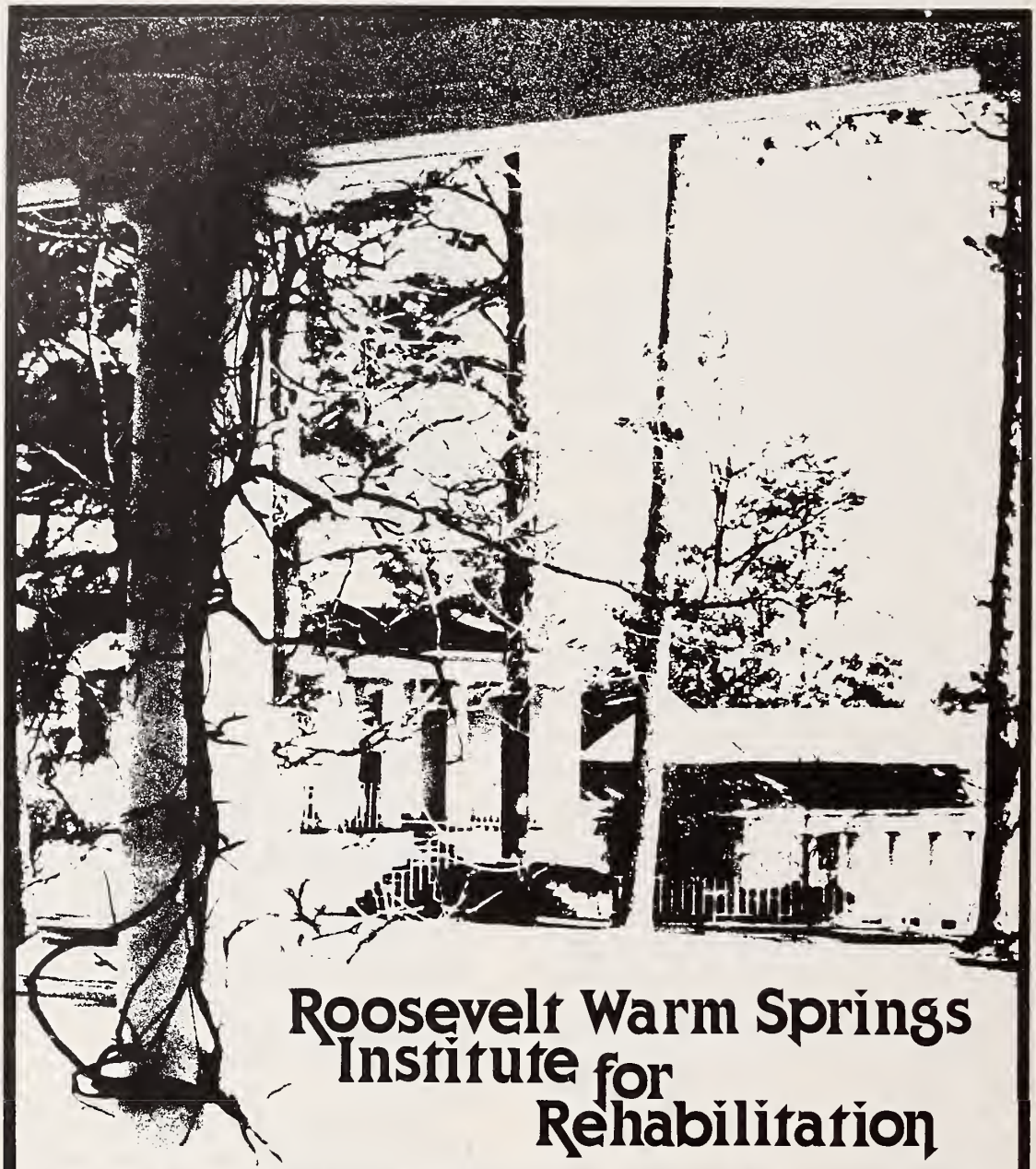
REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your committee advises the adoption of the recommendations as contained in the committee report:

(1) That MAG Executive Committee appoint a delegation from its own members to meet with the appropriate higher officials of the schools training PAs to urge discontinuation of the PA programs until the need for more PAs can be documented. This delegation should base its position on the ''MAG Position Statement On Physician's Assistants'' previously adopted by the MAG Board of Directors.

(2) That the committee on PAs continue to request representation at meetings of the Composite State Board of Medical Examiners when PAs are the principal topic of discussion, for the purpose of exchange of information and appropriate input into revision of the rules and regulations for PAs.

(3) That the Committee on PAs study the development, training, and certification of the specialty PA to insure that there are adequate controls on this type of PA, and that a report be brought back to the 1981 House of Delegates.



Roosevelt Warm Springs Institute for Rehabilitation

Continuing Comprehensive Rehabilitation Services for the medically stabilized patient who is ready for an intensive rehabilitation program.

- Medical Direction/Consultation
- Physical Therapy
- Occupational Therapy
- Rehabilitation Nursing
- Orthotics
- Speech Pathology
- Self Care
- Independent Living
- Rehabilitation Outpatient Clinic
- Vocational Training
- Psychology
- Program for Deaf-Blind
- Counseling
- Social Services
- Comprehensive Epilepsy Program

Referral by physicians, rehabilitation counselors, insurance companies
Costs vary with services; third party payments
For information call (404) 655-3321

Accredited by JCAH and CARF

GEORGIA DEPARTMENT OF HUMAN RESOURCES

(4) That the Committee on PAs continue to monitor the activities of PAs and their employing physicians to insure that the utilization of PAs does not lead to abuses in medical care which might be harmful to patients.

HOUSE OF DELEGATES ACTION

Adopted each of the four recommendations made by the Committee on PAs and reiterated by the Reference Committee.

Mr. Speaker, your Reference Committee heard considerable testimony indicating that ultimately the actions of PAs are the responsibility of the supervising physician.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, for that reason, your Reference Committee further recommends that each component society be directed to assign, within the appropriate committee structure of said society, the task of educating members of that society in the proper and ethical use and supervision of PAs, in order that no physician inadvertently contribute to the misuse of PAs to the detriment of patient care.

HOUSE OF DELEGATES ACTION

Adopted the recommendation of the Reference Committee.

Mr. Speaker, your Reference Committee also agreed with testimony calling attention to the adverse publicity associated with our previous efforts to communicate the views of this Society to the universities, in particular, and to the community at large.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, in order that this possibility be eliminated, or at least markedly reduced, your Reference Committee further recommends that the Public Relations Committee and the Legislative Committee be advised in advance of the date on which our current position statement shall be presented to the appropriate university personnel. The Public Relations Committee and the Legislative Committee shall, at that time, exert their good offices and influence in whatever manner they feel would best emphasize to all concerned, including the public, the positive aspects contained in the rationale, and the position statement resulting from that rationale as contained in the report above.

HOUSE OF DELEGATES ACTION

Adopted the recommendation of the Reference Committee.

RESOLUTION 26
POSITION STATEMENT ON HEALTH MAINTENANCE ORGANIZATIONS

DeKalb Medical Society

WHEREAS, several Health Maintenance Organizations (HMOs) are in various stages of development in the State of Georgia, and

WHEREAS, there is considerable confusion within the medical community concerning the advisability of participating in HMOs, and

WHEREAS, the MAG should develop a position statement regarding HMOs, therefore, be it

RESOLVED, that the House of Delegates adopt the findings of fact and conclusions contained in the attached position statement as an official MAG position statement, and be it further

RESOLVED, that this position statement be distributed to all Georgia United States Senators and Congressmen, all Georgia Legislators, the U.S. Department of HEW, the Georgia Insurance Commission, and the Georgia Department of Human Resources in an effort to change the present legislation regarding HMOs, and be it further

RESOLVED, that all MAG members be notified of this fact that this position statement has been distributed to such governmental officials and agencies.

POSITION STATEMENT ON HEALTH MAINTENANCE ORGANIZATIONS

PREAMBLE

In 1973, the Federal HMO Act (P.L. 93-222) was signed into law authorizing substantial federal funds to be spent in the establishment and development of Health Maintenance Organizations. Amendments were passed in 1976 and 1978 increasing the government's commitments to prepaid health care by extending the authorization for grants and loans through fiscal year 1981. Initially, developmental grants (outright gifts) for the purpose of studying the feasibility of an HMO can go as high as two million dollars. Subsequent loans to assist in development and implementation can reach four million dollars.

The HMO can take two basic forms, closed-panel or Individual Practice Association (IPA). Under the closed-panel concept, the HMO can employ its own physicians on a salaried basis or contract with one or more medical groups to provide care on a prepaid, per capita basis. On the otherhand, the HMO can contract with an IPA, a separate legal entity consisting of physicians who collectively enter into contractual arrangements with other parties, to provide medical services from their offices to a defined population. Physicians who join the IPA must: (1) sign an agreement to conduct their medical practice in accordance with the purposes and policies of the IPA, (2) comply with peer review established by the IPA, and (3) accept a portion of the financial risk by placing a percentage of their fee, usually 20%, in a fund which they receive *only* if the IPA operates within certain financial parameters (established actuarially).

In metropolitan Atlanta, including DeKalb County, there are three HMO's in various stages of development and numerous others being considered. Two of the HMO's under development are IPA's and the other is a church-affiliated, closed-panel model. Although the collective enrollment goal of these HMOs is modest (75,000 families within the next 3



Robert E. Wells, Atlanta, Vice-Chairman of Reference Committee A, makes his report to the House.



Vice-Speaker, Jack F. Menendez, M.D.

years), the impact of this alternative delivery system should not be underestimated. The ultimate choice of participating in an HMO rests with the individual, so each physician must decide whether the goals and objectives of the HMO is consistent with his or her personal goals in the delivery of medical care.

CONCLUSIONS

After meeting with representatives from HMOs, insurance companies, and perusing many documents, articles, and position statements on the subject, the following conclusions were reached regarding HMOs:

(1) The patient's ability to choose his or her personal physician, or site of care, is impaired in that with rare exceptions only those physicians contracting with the HMO can be utilized.
(2) In most cases, physicians must limit their selection of consultants to those participating in the HMO.
(3) Personalized medical care (that is the tradition in Georgia) could be seriously affected due to the restrictions imposed on the physician and the patient by the HMO.
(4) The concept of financial risk-sharing by physicians pressures the physician to ration care, potentially to the detriment of the patient.
(5) The increased financial pressure on a physician practicing in an HMO may lead to poor medical judgement, which results in increased exposure to liability and altered practice patterns.
(6) Prepaid health care, without a deductible or adequate co-insurance, encourages over-utilization and potentially offsets any cost savings that might result from efforts of the HMO to limit inpatient care, delay surgery, and restrict services due to the lack of available funds.
(7) Controls will be placed on the physician in the form of required second opinions, pre-admission certification, peer review, and utilization review for financial purposes and establishment of financial practice profiles, all with the primary purpose of cutting hospital utilization and disciplining physician members whose patients and practice patterns consume too many HMO dollars.

REFERENCE COMMITTEE DISCUSSION

Your Reference Committee received more than 2 hours of testimony on this subject, which is of the greatest importance to the citizens of our state and the physicians of our organization. Your committee wishes to commend those who presented information on the factual and detailed material provided to the committee and particularly to commend our members for their courteous and thoughtful cooperation with the committee in covering the vast amount of material in a decorous and orderly fashion.

Your committee feels the responsibility to attempt a summary, however meager, of the information presented in the course of this long discussion. The following summary is representative but by no means complete:

(1) The patient's ability to choose his or her personal physician, or site of care, is impaired in that, with rare exceptions, only those physicians or hospitals contracting with the HMO can be utilized.

(2) In most cases, physicians must limit their selection of consultants to those participating in the HMO or IPA.

(3) Personalized medical care (that is the tradition in Georgia) could be seriously affected due to the restrictions imposed on the physician and the patient by the HMO or IPA.

(4) The concept of financial risk-sharing by physicians pressures the physician to ration care, potentially to the detriment of the patient, and increases his



Richard E. DuBois, Atlanta, reports to the House about proposed changes in the AMA's Code of Ethics.



MAG's new Second Vice-President, William C. Collins, of Atlanta.

exposure to liability.

(5) Prepaid health care, without a deductible or adequate co-insurance, encourages over-utilization and potentially offsets the cost savings that might result from efforts of the HMO to limit in-patient care, delay surgery, and restrict services.

(6) Controls may be placed on the physician in the form of required second opinions, preadmission certification, peer review and utilization review for financial purposes, and establishment of financial practice profiles, all with the primary purpose of cutting hospital utilization and disciplining physician members whose patients and practice patterns consume too many HMO or IPA dollars.

(7) Certificate of Need guidelines at the federal level are modified in favor of HMO/IPAs.

In spite of the preponderance of negative testimony cited above, respected senior members of this society, whose integrity and dedication to the ethical practice of medicine is unquestioned, offered conflicting testimony:

(1) Proper fiscal management can maintain an appropriate level of service at competitive costs.
(2) Proper exercise of clinical judgement can reduce the cost of medical care without diminishing the quality of medical care.
(3) An ethical physician would, in any event, terminate his or her association with any delivery system that resulted in the unduly restrictive conditions on the doctor/patient relationship as described in the preceding negative testimony.

In view of the foregoing, your Reference Committee debated at length with the greatest of concern and consideration.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee elected to amend Resolution 26 by substitution as follows:

BE IT RESOLVED, that the House of Delegates adopt, as the MAG Position Statement on Health Maintenance Organizations, the following language:

POSITION STATEMENT ON HEALTH MAINTENANCE ORGANIZATIONS

"In 1973, the Federal HMO Act (P.L. 93-222) was signed into law authorizing substantial federal funds to be spent in the establishment and development of Health Maintenance Organizations. Amendments were passed in 1976 and 1978 increasing the government's commitments to prepaid health care by extending the authorization for grants and loans through fiscal year 1981. Initially, developmental grants for the purpose of studying the feasibility of an HMO can go as high as $2 million each. Subsequent loans to assist in the development and implementation can reach $4 million.

The HMO can take two basic forms, closed-panel or Individual Practice Association (IPA). Under the closed-panel concept, the HMO can employ its own physicians on a salary basis or contract with one or more medical groups to provide care on a prepaid, per capita basis. On the other hand, the HMO can contract with an IPA, a separate legal entity consisting of physicians who collectively enter into contractual arrangements with other parties to provide medical services from their offices to a defined population. Physicians who join must:

(1) Sign an agreement to conduct their medical practice in accordance with the purposes and policies of the IPA;
(2) Comply with peer review established by the IPA and;
(3) Accept a portion of the financial risk by placing a percentage of their fee, usually 20%, in a fund which they receive *only* if the IPA

operates within certain financial parameters (established actuarially).

In metropolitan Atlanta, there are four HMOs in various stages of development and others are being considered both in Atlanta and various portions in the state of Georgia. Three of the HMOs under development are IPAs and the other is a church-affiliated, closed-panel model. Although the collective enrollment goal of these HMOs is modest (75,000 families within the next 3 years), the impact of this alternative delivery system should not be underestimated. The ultimate choice of participating in an HMO rests with the individual physician, so each physician must decide whether the HMO's goals and objectives, as well as methods of achieving those goals and objectives by the HMO, are consistent with his or her personal goals in the delivery of medical care.

Superb management is crucial if any HMO-IPA is to have any possibility of achieving their stated goals. The assurance of such high quality management is difficult to ascertain in advance of actual operation.

The MAG expresses its deepest concern regarding any method of health care delivery that limits the patient's choice of a physician or limits the physician's choice of an appropriate consultant.

The MAG considers any health care vehicle which invites a physician to increase his or her remuneration by restricting diagnostic and/or treatment services to represent an unacceptable and obvious conflict of interest which is to be avoided at all costs.

The MAG supports the concept of consultation (second opinion) whenever it is requested by the patient or deemed necessary by the physician. The Association has always held the opinion that careful clinical judgement should be exercised in the selection of patients for hospital care. The Medical Association relies upon collective medical judgement of our peers in order to determine the appropriate levels of patient care. We deplore and condemn the subversion of these traditional medical practices for the purpose of cost reduction, relegating the health of the patient to a secondary role."

Mr. Speaker, your Reference Committee recommends that the resolution as amended be adopted.

HOUSE OF DELEGATES ACTION

In light of the provisions of the current Georgia law relating to HMOs, the House of Delegates agreed to add an Item 4 in the content of this Statement immediately following the three items listed which "Physicians who join must" do. This addition reads: (4) Open their records pertaining to the quality of health care to the Commissioner of Human Resources, for the purpose of examination as often as he deems necessary, but at least every 5 years.

Mr. Speaker, your committee also recommends that this position statement be distributed to all Georgia United States Senators and Congressmen, all Georgia legislators, the U.S. Department of HEW, the Georgia Insurance Commission, and the Georgia Department of Human Resources in an effort to change the present legislation regarding HMOs.

HOUSE OF DELEGATES ACTION

Each of these recommendations of the Reference Committee was adopted.

REFERENCE COMMITTEE RECOMMENDATION

It is further recommended that all MAG members be notified of the fact that this position statement has been distributed to such governmental officials and agencies.

HOUSE OF DELEGATES ACTION

Adopted this recommendation of the Reference Committee.

RESOLUTION 22
DISAPPROVAL OF SUPPORTING A SINGLE HEALTH CARE DELIVERY SYSTEM

F. W. Dowda, M.D. — Delegate MAA

BE IT RESOLVED, that MAG go on record as disapproving federal and state support of any one type of health care delivery system over another, and be it further

RESOLVED, that MAG approve repeal of the current federal HMO law, and be it further

RESOLVED, that this resolution be introduced by the MAG-AMA Delegation at the July 1980 AMA House of Delegates.

REFERENCE COMMITTEE DISCUSSION

This report requests that "the MAG approve repeal of the current federal HMO law" and that it further instruct the MAG-AMA Delegation to introduce this resolution at the July 1980 AMA House of Delegates. Your Reference Committee is of the opinion that the introduction of resolutions to the AMA should be maintained at an absolute minimum, so that the efforts and energies of our delegation will not be dissipated unduly.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, in accordance with that philosophy, your Reference Committee recommends that Resolution 22 be not adopted.

HOUSE OF DELEGATES ACTION

The House voted to not adopt the Reference Committee's recommendation, and adopted Resolution 22 as originally presented.

COMMITTEE ON PUBLIC RELATIONS

Charles W. McDowell Jr., M.D., Chairman

The Public Relations (PR) Committee is continuing



WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℂ

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk es compered to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

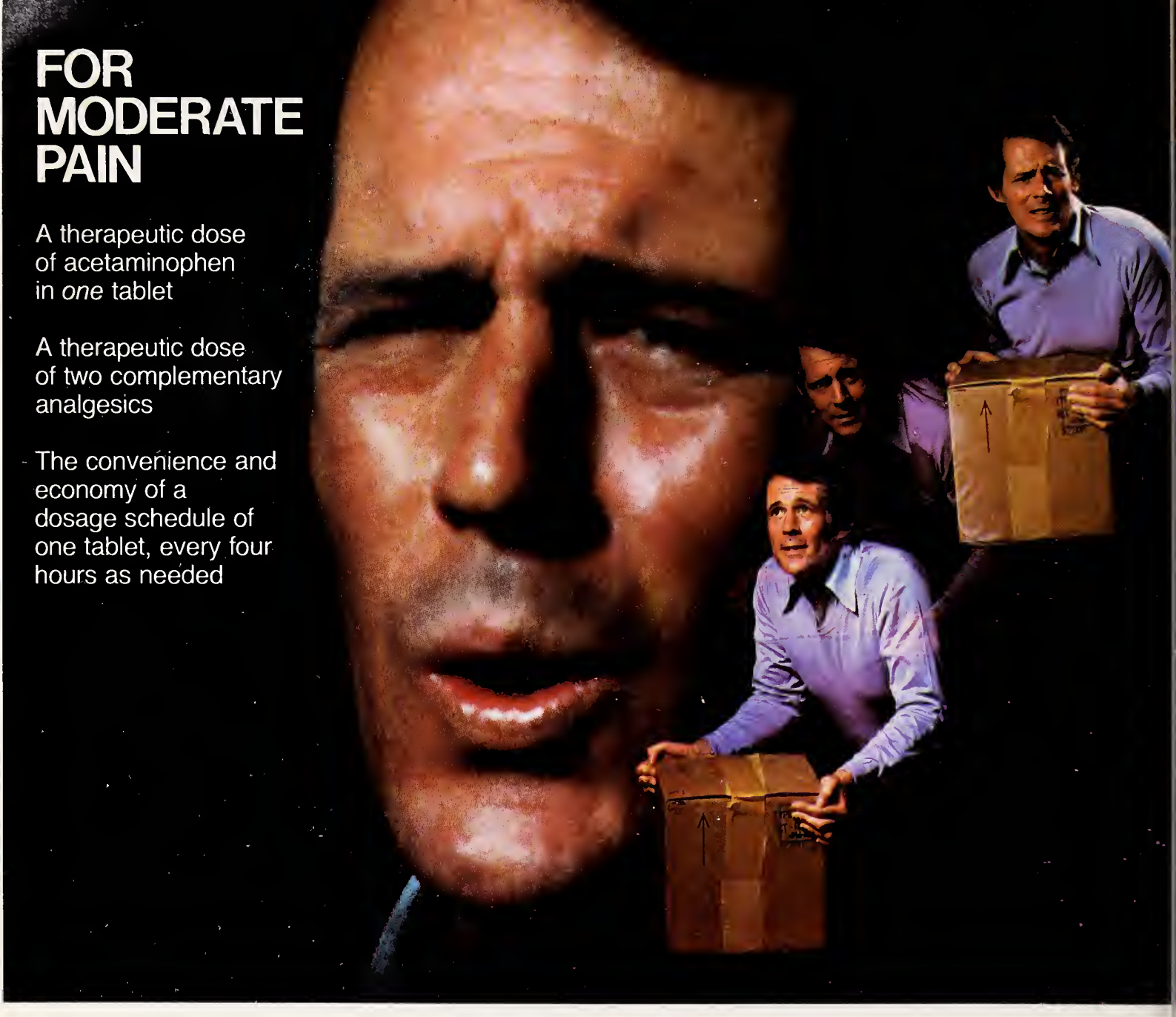
Wyeth Laboratories
Philadelphia, Pa 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® ℂ℣

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright ©1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa. 19101



F. William Dowda, M.D.

to actively pursue its programs and goals as outlined to the Executive Committee at its goal-setting meeting last June. The Executive Committee at that meeting endorsed the PR Committee's philosophy and goals which are:

* To ascertain the public's feelings about physicians and organized medicine, to correct any false information, and to rectify faults in ourselves and our system.
* To educate physicians as to the importance and value of good public relations.
* A positive approach to the individual physician in regards to his practice patterns and overall image and the creation of a closer association between the individual physician and his professional organization, the MAG.
* To eliminate the adversary relationship between some physicians in Georgia and organized medicine.
* To create an organizational image to improve the morale of all physicians and the MAG staff.
* To expand on the current physician/patient relationship to include organized medicine. Currently many feel his doctor is OK, but those other doctors (organized medicine) are something else.
* To communicate more effectively with those that shape public opinion — the media.

We have found that physicians continue to rank among the most respected of all the professions. The public overall continues to express a high degree of satisfaction with their personal doctor. Since March of 1977, the positive aspects of public attitudes towards medicine have diminished somewhat. Generally, the public thinks his individual physician is great but has far less positive views toward organized medicine.

We are developing a patient questionnaire to be placed in each cooperating physician's office to better determine how the public perceives Georgia physicians. More on this later in this report.

The PR Committee last fall began an educational campaign to better educate the state's physicians as to the importance and meaning of good PR. We began with an all-member mailing, talking of the committee's activities, and held a statewide PR conference in January covering such topics as, "What Does the Public Think of Medicine?," "Communicating Medicine's Story," and "Working with the Media."

Despite personal invitations which were sent to all county society presidents asking for participation by the secretary, president-elect and PR chairman, only 15 county medical societies were represented at the PR conference. Additional invitations were extended to specialty society presidents, the MAG Executive Committee, Board of Directors, and all MAG committee chairmen. Approximately 70 participants attended.

The PR Committee is recommending that each county society consider sponsoring a mini-PR workshop with the assistance of the MAG. We are also recommending another statewide conference next year.

The MAG radio show, "For Good Health," continues to be broadcast statewide to over 100 stations via the Georgia Network. The PR Committee is recommending that once the current programming ends in October of 1980, that the project of "For Good Health" be turned over to the MAG Auxiliary on a local basis. A Communications Workshop to educate Auxiliary members in how to produce the show is scheduled for June 17th at Callaway Gardens.

The PR Committee has contacted all Georgia radio and TV stations and supplied them with public service announcements (PSAs) scripted by the AMA. The committee is hopeful that the county medical societies will cooperate with the MAG in supplying additional PSAs to the stations. For those county societies who wish to better relate with the electronic media in their respective areas, this is one good way to do so. MAG will provide each county society, who so requests, four to five PSAs each month, and they in turn can edit, modify, or localize the PSAs to their choosing and supply them to the station.

We have also contacted all the state's newspapers and provided sample articles to them on medical topics of general public concern. We, again, will supply the county societies who are interested with these AMA scripted columns so the county societies can modify such articles as may best suit that community's interests. That will also give better name recognition to the county societies and again provide the county societies an additional opportunity of working with the media.

The PR Committee has pushed for the expansion of Tel-Med to all parts of the state. Four additional Tel-Meds have been installed since our report last year. They are in: Atlanta, Gainesville, Macon, and Douglas County. The committee encourages other county medical societies to consider becoming a part of an excellent method of providing taped health messages which are accessible to the public via the telephone.

We are distributing to all the Association's members a patient questionnaire to assist the physician in better determining how his patients feel about him. The questionnaire

should be used by the cooperating physician as one instrument in improving the physician/patient relationship. The PR Committee believes that an improved relationship between organized medicine and the public must begin in each physician's office.

The committee continues to encourage county societies to organize health forums open to the public on health-related topics. Several county societies are already sponsoring such forums, and they, for the most part, have proven to be enormously successful. Should your society be interested in sponsoring such forums, please contact Ken Williams of the MAG as he can provide packets of materials to help in the formation of such meetings.

The committee is recommending a quarterly PR NEWSLETTER to be printed at MAG but designed so that county societies can share with one another what each is doing in improving public relations. Such a NEWSLETTER will also offer PR tips and suggestions for county societies to consider.

The PR Committee has also strongly encouraged county societies to organize speakers bureaus. Two societies this year have called upon Mr. Mort Enright, AMA's Director of Speakers and Leadership Programs, to conduct formal training sessions on speakers bureaus. Those societies are Muscogee and DeKalb. Additional societies who are interested in organizing such programs should contact the MAG or the AMA.

MAG has issued news releases all year long to all the state's newspapers, radio and TV stations on such topics as "Raising the Drinking Age," "Cutting Health Care Costs," "Better Patient Care — Number One Priority," etc.

MAG has also responded to numerous adverse media comments by letters to the editor or by scheduling physician leaders on radio or TV.

It has been a busy year at MAG for your PR Committee. We shall always strive to represent you as best we can.

As chairman of the PR Committee, I wish to personally thank each of you who has donated time and effort to make our tasks a little easier. We have taken that first step in that thousand mile journey.

RECOMMENDATIONS

1. That the PR Committee initiate a quarterly PR NEWSLETTER as discussed earlier in this report.
2. That the statewide PR Workshop conducted last year be repeated if necessary as outlined in this report.
3. That the committee conduct PR Workshops at the county society level where requested.
4. That the committee continue the public service announcements as outlined in its report.
5. That the committee continue to work with county societies to expand Tel-Med in Georgia.
6. That the committee sponsor a workshop for physicians' office personnel to improve their PR skills, e.g., answering the phone, scheduling, patient confidentiality, patient-doctor relationship, etc.
7. That county societies be strongly encouraged to establish their own PR committees and that the chairmen serve as an advisory council to the MAG PR Committee.
8. That all MAG committees be charged and the specialty societies be requested to draft position papers on medical topics within their jurisdiction to ultimately be publicly disseminated as part of MAG's PR efforts following approval by the MAG Board of Directors.
9. That all county societies consider sponsoring workshops on how to establish speakers bureaus to be conducted by the staff of AMA's Leadership and Speakers Program.
10. That the committee engage professional public relations talents outside the Association, if and when necessary.

REFERENCE COMMITTEE DISCUSSION

Your Reference Committee heartily endorses the content of this committee report. Your Reference Committee urges members of this House to seek, from your component societies, the utmost cooperation for Dr. McDowell and his committee members in the coming year.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends adoption of the Recommendations 1 through 10 as contained in the report of the Committee on Public Relations.

HOUSE OF DELEGATES ACTION

Adopted each of the 10 recommendations contained in the report of the Committee on Public Relations, as recommended by the Reference Committee.

MEDICAL PRACTICE COMMITTEE

W. Dan Jordan, M.D., Chairman

There were multiple areas of interest and activity for the medical practice area in the past year. For ease in reference, these are addressed in accordance with the different subject matter.

Investigation of Primary Health Care and/or Rural Health Clinics: In accordance with the 1979 House of Delegates charge "that the Medical Practice Committee be responsive to inquiries concerning inadequate care in primary health care clinics by their local investigation," questionnaires were distributed to 31 clinics and responses compiled and evaluated within the limited degree of response. While in the process of investigating these clinics, the Medical Practice Committee was also requested to respond to a request from the Board of Medical Examiners to establish a basic protocol. The committee felt that it needed to make on-site evaluations of clinic situations including protocols to identify problem areas before any effort was made to offer assistance to the Composite State Board of Medical Examiners in the development of guidelines to review protocols. The methodology and forms for conducting further investigations by physician members of the Committee were developed.

It was determined that the review would be quite limited since the Committee had no authority for investigation. Therefore, it was suggested that the individuals who would review the clinics be appointed as agents of the Composite State Board. The Executive Committee wrote

to the Composite State Board requesting that the members of the Medical Practice Committee be appointed as agents of the Board. The net result of this action was that the Commissioner of Human Resources appointed a subcommittee of the Composite State Board of Medical Examiners consisting of five members of the Medical Practice Committee, one representative of the Georgia Osteopathic Association, two representatives from the Georgia State Medical Association, one representative from unorganized medicine, and two at-large members. Inasmuch as the MAG members composed the majority of this committee, the October Executive Committee decided further investigation of the clinics could be conducted effectively through this Committee of the Composite State Board of Medical Examiners. The Composite State Board of Medical Examiners wrote to each of the primary health care centers in the state requesting copies of their protocols.

At the time of this report, the Protocol Committee has met one time. Discussion was centered primarily around the purposes of the committee. It adopted the following statement of purpose: "To review the current available protocol being used by nurse practitioners in the state and develop, if possible, a standard protocol for guidance of the Composite State Board of Medical Examiners, including rules and regulations under which the various clinics operate." Committee members will review protocols that have been submitted to the Composite State Board and will also review a book entitled "Patient Care Guidelines for Family Nurse Practitioners" in an effort to determine if a basic protocol can be developed.

Related Actions by the Board of Human Resources: The Physical Health Subcommittee of the Board of Human Resources requested MAG to report its concerns about "clinics per se" to that committee. However, by the time the meeting was finalized, it had developed into a request for response to a revised version of *Primary Health Care: A Perspective,* developed and prepared by the Division of Physical Health, DHR. This Perspective is the overall justification for the existence of clinics within the state. Joe Stubbs, M.D., Chairman of the Board, served as spokesman for the Association at a September meeting. The Perspective is now being rewritten. The Board of Human Resources adopted the following resolution at its October meeting:

"WHEREAS, the Georgia Health Code (Sections 88-108 and 88-203) provides that the Department of Human Resources has a clear responsibility to assure that the primary health care needs of the citizens of Georgia are met, and

WHEREAS, certain areas of Georgia are identified as medically unserved or underserved by statistics reflecting primary care physician population, infant mortality rates, aged population, and poverty, and

WHEREAS, the Department has the additional stringent obligation to exercise maximum efficiency and economy in its various responsibilities, be it therefore

RESOLVED that the Department assist such areas designated as medically unserved or underserved by, (1) identification and recruitment of available health provider personnel, and (2) providing administrative assistance in seeking those public funds available for the delivery of primary health care, and (3) providing basic educational, managerial, and laboratory support to community-based public programs offering primary health care, and be it further

RESOLVED that public programs offering primary health care be implemented only in those communities and/or identifiable areas where (a) the community/area requests it and provides proper plans for utilization of such programs, and (b) where programs are in accord with the projected plans and goals of appropriate regional planning agencies, and (c) where documentation exists that the projected plans have been discussed with the private health sector.

This 17th day of October, 1979."

The DHR's definition of primary health care is: "Primary health care is that level of care which emphasizes both first contact and continuing care. This level of care shares the ongoing responsibility with the individual for treatment of illness, prevention of disease, and health maintenance. It includes the overall coordination of biological, behavioral, and social care, and referral to other health and community resources when indicated." The October Executive Committee considered this definition at the request of the North Central Georgia HSA. The Executive Committee approved the concept with the revision to the first sentence, which would make the first sentence of the definition read: "Primary health care is that level of care which emphasizes both first contact and continuing care provided by those individuals licensed under Georgia Code 84-9 (Medical Practice Act)."

As of March, 1980, there are 42 primary health care centers operational in Georgia. Several others are in the planning stages. A copy of the list including names, addresses, names of administrators and/or providers are available upon request through the MAG office.

Health Maintenance Organizations: Two health maintenance organizations in Atlanta — Health Care, Inc., and Metro Atlanta Health Plan — were operationally effective January 1, 1980. Health Care, Inc. is treating patients under a group practice arrangement. Metro Atlanta Health Plan is an IPA model.

The Georgia Medical Plan, another IPA model, is in the developmental stage and plans to be operational January, 1981. Two medical societies are in the process of investigating the possibility of developing an IPA. Some insurance companies are also discussing possibilities.

A Georgia Conference on HMOs was held December 13 at the Atlanta Hilton, sponsored by the Group Health Association of America, which is primarily a group model HMO association. The express purpose of the conference was to familiarize Georgia's leaders in business, labor, health care, and government with the HMO concept and its potential for cost effective health care programs. This conference was attended by approximately 200 representatives, primarily from business and insurance companies. Emphasis was placed by all the speakers on the cost-saving aspects of this medical care delivery system. Greater emphasis was placed on the involvement of the

private sector vs. utilization of federal funds to implement programs.

Currently, there are 203 HMOs operating nationwide, with a total enrollment of 7.4 million people. It is projected that by 1988 there will be 422 operating, covering 19.1 million people. A September, 1979, publication of the Public Health Service of the Department of HEW, entitled, "National HMO Development Strategy Through 1988," is available upon request at the MAG office.

The Medical Practice Committee has reviewed proposed DHR rules and regulations relating to quality of care within the HMOs. At the committee's request, the MAG filed comments to a March 21, 1980, hearing held on these regulations. A copy of these comments is attached.

Medical Staff Application Form: Concern has developed because of correspondence and inquiries received from physicians which relate to the extent of immunity and release from civil liability which is granted in some applications. Informal communication with legal counsel has emphasized the importance of the physician being completely aware of the ramifications of the waiver form. To this end, the committee anticipates the development of a model waiver form for use in the medical staff privilege application form.

RESOLUTION 23
RURAL AND URBAN HEALTH CLINICS

Georgia Medical Society

WHEREAS, the Department of Human Resources, National Health Service, and the Public Health Service have developed rural and urban health clinics in underserved areas of Georgia, and

WHEREAS, these rural and urban health clinics are responsible for the total primary care of patients in its area, and

WHEREAS, in some instances, it appears the form of diagnosis and treatment of acute illness is a departure from the traditional philosophy in the public health area, and is traditionally considered the province of the private practice of medicine, and

WHEREAS, the Cobb County Medical Society presented Resolution No. 12 to the House of Delegates, 1978, which was adopted:

"RESOLVED, that the MAG develop close liaison with those setting up such rural health clinics, and be it further,

"RESOLVED, that the MAG study the care in those areas already being served by the Public Health Department in such clinics as: family planning clinics, mental health clinics, in order to assess the quality of care, cost effectiveness of such care, and the continuity of such care. Deviation from accepted standards of care and/or cost are to be reported to the Board of Directors before Jan. 1, 1979, for appropriate action."

WHEREAS, the above study has *not* been done, and

WHEREAS, since 1978, other clinics have been established, and previously physician-staffed clinics are now staffed only by nurses, and

WHEREAS, there is grave concern in some areas of the state as to the cost effectiveness, efficiency of utilization of service provided in these clinics, the adequacy and extent of physician supervision of these nurses, nurse practitioners, and physician's assistants, and

WHEREAS, the MAG is dedicated to assurance of cost effective *quality* care, now, therefore, be it

RESOLVED, that the MAG establish as one of its priorities for the forthcoming year, a study of those clinics operating in areas which are already being served by the Public Health Department in such clinics as: family planning clinics, mental health clinics, cancer detection clinics, other public health clinics, in order to assess the quality of care, cost effectiveness of such care, the continuity of such care, the adequacy of physician supervision, and whether there is duplication of services by agencies or clinics. Instances of duplication of service, as well as deviations from accepted standards of care and/or continuity of care, inappropriate cost of care, and adequacy of physician supervision of non-physician personnel are to be reported to the Board of Directors before Jan. 1, 1981, for appropriate action.

REFERENCE COMMITTEE DISCUSSION

The Medical Practice Committee report addressed itself to the investigation of primary health care and/or rural health clinics in the past year. The report does not contain any recommendations. Your Reference Committee elected to consider it in conjunction with Resolution 23, submitted by the Georgia Medical Society, which calls for an intensive investigation of rural and urban health clinics. In addition to comments from other delegates, your committee heard testimony from members of the Georgia Medical Society, the Chairman of the Medical Practice Committee, and the Chairman of the Access to Health Care Committee. Each of these individuals, from their particular perspective, emphasized the enormous problems in attempting to obtain information, let alone carry out, an in-depth study of even one such clinic. The implications were clear that those active in this area considered it impossible, at this point in time, for the MAG to mount an appropriate in-depth study. The problems are manifold. Specific difficulty has been encountered in obtaining information. Cooperation from the individuals responsible for these various clinics has been minimal or passive. Although many of our colleagues are active in public health clinics, your committee was unable to obtain input from any physicians associated with other federally or state funded clinics that are not specifically a part of the public health system. It is precisely those clinics where your current committees have failed to acquire information. The Georgia Medical Society did report some success, at least to the extent of having appropriations reduced, for one such clinic in their area.

Your committee is eminently sympathetic with the desires expressed in the RESOLVE portion of the Georgia Medical Society Resolution. However, it is the conviction of your committee based on ample detailed

testimony that it is difficult to institute such a far ranging, albeit desperately needed, enterprise.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, with reluctance, therefore, your Reference Committee elected to amend Resolution 23 by substitution as follows:

"BE IT RESOLVED, that the Medical Practice Committee not only be commended for their efforts of the past year but also that these dedicated individuals be encouraged to persevere in spite of their relative lack of success, and, be it further

RESOLVED, that the Medical Practice Committee inform each component society of rural and urban clinics operating within the boundaries of the component society jurisdiction.

The component societies are urged to take five specific actions:

(1) To acquaint themselves by whatever means possible regarding the actual operations of these clinics including the degree or frequency of physician availability, the type of treatment or procedures conducted, the cost of these services, and the qualifications of the individuals rendering such treatment.

(2) The component societies are urged to appear at local public hearings where funding for these clinics is discussed in order to inform the public regarding the cost effectiveness of these programs and/or to question the need for services which, in their judgement, are inappropriate, considering the personnel available within the clinic.

(3) The component societies are urged to utilize their public relations network to educate the citizens of their community regarding the activities, including the cost, of these clinics.

(4) The component societies are requested to report immediately to the Board of Medical Examiners, or other appropriate agencies, any evidence or suggestion of impropriety regarding the practice of medicine.

(5) Lastly, the component societies are requested to forward a summary of their information and/or activities to the Medical Practice Committee at their earliest convenience.

Mr. Speaker, your Reference Committee recommends that this Resolution as amended be adopted.

HOUSE OF DELEGATES ACTION

Adopted Resolution 23 as amended by the Reference Committee.

RESOLUTION 8
CONTROL OF NURSE PRACTITIONERS OF MEDICINE

Bibb County Medical Society

WHEREAS, The Department of Human Resources (DHR) of the State of Georgia is practicing medicine using nurse practitioners, and

WHEREAS, no one in the State of Georgia is farther than 20 to 30 minutes from traditional physician-administered medical care; and

WHEREAS, the DHR clinics as structured can only render second-class care at high cost to the taxpayers, and

WHEREAS, the Attorney General of the State of Georgia has ruled that "protocol medicine" does not violate the State Medical Practice Act, and

WHEREAS, the Georgia State Board of Nursing has unilaterally defined "nurse practitioner" and rules and regulations for same, and

WHEREAS, nurse practitioners are attempting to practice medicine without proper medical school training, and

WHEREAS, the Medical Practice Act is enacted to protect the public from illegal and unqualified practitioners of medicine and surgery, therefore, be it

RESOLVED, that the MAG proceed to propose legislation to bring nurse practitioners under the jurisdiction and supervision of the Composite Board of Medical Examiners by amending the Medical Practice Act, Section 84-906 (b) (8) "(8) The licensed practice of midwifery or nursing; provided, however, that, for the purpose of this Section, the licensed practice of nursing or midwifery shall not be deemed to include the administration of medications or medical treatments unless said medications and medical treatments are prescribed by and administered under the direct personal supervision of an appropriate licensed health professional. 'Direct personal supervision' shall mean daily consultation with an appropriate licensed health professional who has reviewed the patient's condition on a daily basis. 'An appropriate licensed health professional' shall mean: (a) a physician or osteopath licensed in accordance with the provisions of this chapter; (b) a dentist licensed in accordance with the provisions of Chapter 84-7; or (c) a podiatrist licensed in accordance with the provisions of Chapter 84-6; so long as the nurse or midwife reasonably believes such health professional to be acting within the scope of his or her license"; or other suitable language to accomplish the same end.

REFERENCE COMMITTEE DISCUSSION

Various members spoke before the committee regarding the historical evolution of the nurse practitioner concept together with what many perceive as an inappropriate extension of their duties in the absence of adequate supervision by the physician. A number of members commented on the specialized skill of many nurses functioning in intensive cardiac care units and/or other specialized areas of medical endeavor. The remarks made to your committee by all concerned stress the need to have adequate supervision where it is lacking, without restricting the utilization of nurses in properly supervised settings. Additional comments were heard regarding the futility of a pro forma endorsement of legislative action without the intensive and extraordinary support of the membership. Your committee essentially agreed with all the points presented. It is the opinion of your committee that these related viewpoints can best be implemented by amending Resolution 8 through the process of addition and deletion.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee thereby amends the RESOLVE portion of Resolution 8 as follows:

"BE IT RESOLVED, that, in order to maintain the highest standard of medical care for the patient, permit maximum utilization of skilled nurses, and discharge our inherent duty as physicians to advise the public in matters of health, the MAG proceed to propose legislation to bring nurse practitioners under the jurisdiction and supervision of the Composite Board of Medical Examiners, provided that such legislation will not establish the nurse practitioner as having the authority to practice medicine under the Medical Practice Act."

Mr. Speaker, your Reference Committee recommends that this amended resolution be adopted.

HOUSE OF DELEGATES ACTION

Adopted the resolution as amended by the Reference Committee.

REFERENCE COMMITTEE DISCUSSION

Mr. Speaker, your committee heard extensive testimony, and continued extended discussion in its own deliberation, regarding the failure of similar legislation introduced in the previous session of the General Assembly. It is our conviction that the legislation failed to be adopted in part due to a gross misunderstanding on the part of our membership regarding the meaning and practical results of the legislation. The failure was also due in part to the active efforts of other individuals opposed to any close supervision of nurse practitioners. In the final analysis, however, your committee is convinced that the failure of the legislation to pass was the direct result of apathy on the part of the membership regarding their physical presence in the halls of the legislature at a crucial time in the debate.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, for that reason, your committee further recommends that the proposed legislation not be introduced until such time as the Board of Directors is convinced beyond a reasonable doubt that the membership will wholeheartedly support this legislative action, specifically by their presence at the state capitol, in addition to the usual activities conducted in support of legislation.

HOUSE OF DELEGATES ACTION

Adopted this recommendation of the Reference Committee.



Vice-Speaker Jack F. Menendez (R) from Macon will succeed L. C. Buchanan (L) from Decatur as Speaker of the House in 1981.

COMMITTEE ON NURSING

J. Rhodes Haverty, M.D., Chairman

The Committee on Nursing continued to be active, meeting twice in the past year as part of the Statewide Joint Practice Committee for Medicine and Nursing. The Joint Practice Committee is composed of an equal number of MAG Nursing Committee members and nurses representing the Georgia Nurses Association (GNA). Officers this year have been Mrs. Fran Beall, R.N., Chairman, and John P. Wilson, M.D., Vice-Chairman.

At its meeting last summer, the Joint Practice Committee discussed what its function should be. It was generally agreed that in the last 2 or 3 years the committee had gotten side-tracked onto the issue of extended-role nurses (or nurse practitioners), an issue in which the parent organizations (MAG and GNA) have somewhat opposing views. The committee could not discern any immediate solutions to the opposing views and thought that it might better devote its energies to the basic concept of joint practice, i.e., doctors and nurses working together to provide patient care in various settings.

At its meeting in February, 1980, the Joint Practice Committee discussed proposed goals for the coming year: (1) that the committee sponsor a workshop on changing roles in health care; (2) that the committee develop a statement on standards of care for nursing homes; and (3) that the committee send two of its members (one physician and one nurse) to the National Joint Practice Commission meeting in November, 1980. The committee also discussed rules of operation for the committee, a proposed amendment to the Medical Practice Act requiring physician approval for every ordering and administration of a drug, and Rules and Regulations for Nurse Practitioners as proposed by the Georgia Board of Nursing. With regard to the Medical Practice Act amendment, the committee took the position that the amendment was bad because of the effect it would have on practical aspects of health care. The amendment was subsequently withdrawn by its sponsor. With regard to rules and regulations for nurse practitioners, the committee reached agreement that its 1978 statement on nurse practitioners should provide the basis for a definition of supervision of nurse practitioners which might be acceptable to both the medical and nursing professions.

Reference Committee B



Dan Bateman, M.D.



Thomas Anderson, M.D.



MAG's lawyers Robert Berg (L) and Richard Vincent study the report of Reference Committee A.

RECOMMENDATION

That the MAG reaffirm the definition of supervision of nurses which its Board of Directors adopted in December, 1978: "Physician supervision of a nurse means that the physician is responsible for medical acts performed by the nurse. The supervising physician or his physican designee must be available for daily consultation with the nurse and must regularly and systematically review the medical care (as reflected in charts and notes) of patients seen by the nurse."

REFERENCE COMMITTEE DISCUSSION

Your Reference Committee commends Dr. Haverty and the members of the Committee on Nursing for their diligent efforts in a delicate situation. This report recommends that this House reaffirm the previous definition of "supervision" adopted by the Board of Directors in 1978. Unfortunately, the language contained in that definition, which seemed so clear and unequivocal to your Directors, has been interpreted in a fashion totally divergent from the intent of the Board of Directors. Specifically, the phrase, "the supervising physician or his physician designee must be available for daily consultation" was intended to mean that he would be physically available. It has been interpreted as the supervising physician being available by phone or other distant modes of communication. Your committee was also distressed by the interpretations placed upon the phrase "regularly and systematically review the medical care."

REFERENCE COMMITTEE RECOMMENDATION

For these reasons, and with absolutely no reflection upon the action of the Committee on Nursing, your Reference Committee respectfully recommends that the recommendations contained in Committee Report 24 be amended by substitution as follows:

That the MAG adopt the following definition of supervision of nurses: "Physician supervision of a nurse means that the physician is responsible for the medical acts performed by the nurse. The supervisory physician or his physician designee must be available daily to examine his patient and must regularly and systematically review the medical care."

HOUSE OF DELEGATES ACTION

The House voted to amend the Reference Committee's recommended definition of "physician supervision of nurses" by insertion of the phrase " . . . acting in accordance with his prescription or instruction." at the end of the first sentence of the definition. This would make the entire definition read: "Physician supervision of a nurse means that the physician is responsible for the medical acts performed by the nurse, acting in accordance with his prescription or instruction. The supervising physician or his physician designee must be available daily to examine his patient and must regularly and systematically review the medical care."

The House of Delegates then adopted the recommendation of the Reference Committee as amended by the House.

Mr. Speaker, this concludes the report of Reference Committee B. Your Reference Committee would like to express its appreciation to all who participated in our discussions and deliberations. The members of the Committee were: Jack A. Raines, Columbus, Chairman; John P. Heard, Decatur, Vice-Chairman; Harry Porter Jr., Marietta; Arthur P. Merrill Jr., Atlanta; D. Morton Boyette, Albany; Jimpsey B. Johnson, Augusta. We also would like to thank Mrs. Joyce Butler of the MAG staff for her assistance on our committee.



L. C. Buchanan, M.D., serves his last year as Speaker of the House.

A Special Resolution

Delegate F. William Dowda offered the following resolution which was adopted by acclamation:

WHEREAS, Dr. Leslie Buchanan has served MAG for many years, and

WHEREAS, he now is retiring as Speaker of this House, and

WHEREAS, he has led with fairness, integrity, diligency, and vigor, therefore be it

RESOLVED, that the House go on record at this time and express its sincere appreciation to Dr. Buchanan for his labors in its behalf, and be it further

RESOLVED, that a copy of this resolution be forwarded to Dr. Buchanan appropriately signed by our President, Secretary, and the new Speaker of the House.


Have a Coke®
and a smile.
Coke® adds life.
registered trade-marks which identify the same product of The Coca-Cola Company.

Motrin® vs codeine...

ibuprofen



© 1980 The Upjohn Company

compare the analgesic effect

Motrin (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients. *Motrin* was significantly more effective ($p < 0.01$) than codeine 60 mg at the 2-, 3- and 4-hour intervals...significantly more effective ($p < 0.01$) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

Degree of pain relief—mean scores

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



Data on file at The Upjohn Company.

One tablet q4-6h prn pain

A well-tolerated, nonnarcotic prescription for mild to moderate pain

Motrin® 400 mg TABLETS

ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Acts peripherally
- Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
- The most common side effect with *Motrin* is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

MED B-4-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

J-7835-4 May 1980

Are you paying taxes on your savings interest again this year?

If so, you need to learn about Fulton Federal's Tax Deferrer. It's a savings plan that lets you defer taxes on your interest until you are in a lower tax bracket. With a minimum deposit of $5,000, your funds will be invested in the highest yield for which your account qualifies.* (There's a small annual service fee, as well as a one-time processing fee.) For more information, call or come by the Fulton Federal branch nearest you.

*A substantial interest penalty is required for early withdrawal.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 • Atlanta, Georgia 30301 • 404-586-7283

Report of Reference Committee C

RONALD F. GALLOWAY, M.D., Chairman
EDMUND M. MOLNAR, M.D., Vice-Chairman

Chairman Galloway reported to the House of Delegates that the reports and resolutions referred to Reference Committee C, which met in the Club Room, Atlanta Hilton, on April 25, were thoroughly examined and carefully considered. The members of the Reference Committee were Ronald F. Galloway, Chairman, Augusta; John F. Atha, Rockmart; Charles J. Rey Jr., Austell; Charles R. Richardson, Statesboro; and Keith A. Quarterman, Atlanta. Dr. Atha was called away from the meeting due to a family emergency and was unable to return.

REPORT OF THE VICE-SPEAKER

Jack F. Menendez, M.D.

In the future, we could well experience problems when late resolutions are submitted only a few hours before the opening of the first session of the House of Delegates. Accordingly, I would like to propose a solution that would allow us to deal with this matter in a way that will minimize the likelihood of problems arising.

RECOMMENDATION

I recommend that the House of Delegates authorize your Speakers to formulate a policy of the House of Delegates that will provide that all late resolutions must be submitted to the Headquarters Office by 2:00 PM on the day preceding the opening of the first session of the House of Delegates. Failure to meet this deadline would mean that the resolution would not be considered at that particular meeting of the House of Delegates.

REFERENCE COMMITTEE DISCUSSION

Mr. Speaker, your Reference Committee has carefully considered the report of the Vice-Speaker and agrees with the concern regarding late resolutions presented to the House of Delegates. The report recommends that late resolutions be submitted by 2 PM on the day preceding the opening of the House of Delegates and that resolutions not submitted by this deadline would not be considered in that particular session.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee advises adoption of this recommendation.



(L-R): Charles R. Richardson, Statesboro; John F. Atha, Rockmart, and Chairman, Ronald Galloway, Augusta, study the report of the Public Health Committee as it is discussed in Reference Committee C.

HOUSE OF DELEGATES ACTION

Referred the recommendation of the Vice-Speaker back to the author for reconsideration at next year's House of Delegates.

EMERGENCY MEDICAL SERVICES COMMITTEE

Selwyn T. Hartley, M.D., Chairman

The Committee on Emergency Medical Services undertook several projects in this past year, many of which will be continued into the coming year. The major items of concern to the committee were: the need for physician advisors to ambulance services in the state as a prerequisite for licensing of those services, disaster planning, and the need for burn units in Georgia.

The committee worked closely with the MAG Committee on Legislation in helping to pass legislation requiring ambulance services in Georgia to have a licensed physician medical advisor before those services can be licensed. This law will help to insure that emergency

medical personnel have at least minimal medical supervision. Previously, no such supervision was required and many ambulance services had no established relationships with physicians to advise them on various matters such as emergency procedures, administration of drugs, etc. The committee observed instances in the past year of ambulance companies acting independently when local physicians were unavailable to give emergency orders. We are pleased to report our success in working with the Committee on Legislation to insure that emergency medical technicians (EMTs) have at least minimal medical supervision.

The committee would like to sponsor a seminar in the coming year to educate those physicians who have assumed the role of medical advisor for an ambulance service. Often, these physicians serve without pay to provide general supervision to EMTs in the areas of training, administration of drugs, and other critical areas. The committee will investigate various avenues for sponsoring this meeting, including the possibility of holding the seminar in conjunction with the MAG Scientific Assembly.

The committee also began an investigation into the development of disaster plans in Georgia. It is apparent that physicians have very little input into disaster plans and are largely ignored by local civil defense officials in developing these plans. Physicians should play a key role in triaging patients in disasters, in helping to coordinate critical care services, and in insuring the general safety of citizens. Members of the committee met with representatives of the Georgia Department of Human Resources and the Georgia Department of Civil Defense to discuss this. We are hopeful that some progress will be made in this area in the coming year, but will need the cooperation of these and other government organizations to do so.

The final area of concern to the committee is the need for state funding for burn services in Georgia. Physicians from throughout the state have expressed concern about the difficulty in getting proper medical care for severely burned patients. Currently there is inadequate funding for burn units in the state, and the committee has adopted a recommendation supporting efforts to investigate the need for burn units in the state and to seek state funding for this purpose. We are hopeful that the Joint Emergency Medical Services Study Committee of the Georgia General Assembly will be able to assist our committee in this investigation.

RECOMMENDATIONS

The following recommendations are made as a result of the committee's work this year:

1. That the Committee on Emergency Medical Services work vigorously to insure that the Georgia Department of Human Resources and Georgia Department of Civil Defense actively involve physicians in formulating disaster plans for the state.
2. That the Committee on Emergency Medical Services undertake efforts to investigate the need for burn units in the State of Georgia and to determine the availability of public funds to support these units.
3. That the MAG Committee on Emergency Medical Services sponsor a seminar during the coming year to educate physicians who are medical advisors for Georgia's ambulance services. (see Fiscal Note)
4. That the Committee on Emergency Medical Services continue to work toward insuring that Georgia's ambulance services have proper medical supervision.

FISCAL NOTE: Funds for this seminar will be sought from outside sources. A maximum of $3,000 in MAG funds may be needed should other sources of funds not be available.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends the adoption of Recommendations 1 through 4 of the Report of the Committee on Emergency Medical Services.

HOUSE OF DELEGATES ACTION

Adopted the Recommendations 1 through 4 of the Committee on Emergency Medical Services.

REFERENCE COMMITTEE DISCUSSION

The report of the Committee on Emergency Medical Services describes several new activities undertaken in this past year. These activities include the investigation of burn units, the requiring of medical advisors for ambulance services, and the involvement of physicians in civil defense disaster plans.

The committee's first recommendation asks that the Committee on Emergency Medical Services work to insure that appropriate branches of state government (DHR and the Department of Civil Defense) involve physicians in the development of disaster plans. The committee has observed very few instances in which physicians are actually involved in this important activity. The committee has seen some results of its work in this area, but believes that with continued support it can succeed in its efforts to involve physicians in disaster planning.

The committee's second recommendation calls for an investigation of burn units in the state and raises the possibility of seeking state funding for these units if necessary. The Committee on Emergency Medical Services believes that a study of burn services in Georgia would identify the problems in obtaining burn care and the alternative solutions to these problems. Your Reference Committee points out that this study was requested by the MAG Board of Directors meeting in January, 1980, and believes that this is a worthwhile project for the MAG to undertake.

The committee's third recommendation requests support for a seminar for medical advisors of Georgia's ambulance services. Your Reference Committee notes that MAG supported legislation requiring these advisors and believes that a seminar to assist these advisors in areas of drug use, supervision, training, and other critical areas would be very useful. Funds for this activity have not been budgeted by the MAG Finance Committee. Outside sources of funding will be sought first for this activity, but may not be available. Consequently, MAG funds not in excess of $3,000 may be necessary.

The committee's fourth recommendation asks that the Committee on Emergency Medical Services continue to work towards insuring that Georgia's ambulance services have proper medical supervision. The committee has worked in the past year (with the Committee on Legislation) successfully in requiring medical advisors for most of Georgia's ambulance services and believes that this work should be continued to cover all ambulance services.

PUBLIC HEALTH COMMITTEE

Stephen C. May Jr., M.D., Chairman

Physicians practicing in the private sector generally have a limited interest in public health as a medical field. This general lack of interest manifests itself by a poor understanding by the general medical community of where their responsibilities lie in helping to protect the health of populations as a whole. The outcome of this general lack of interest in public health is that those responsible for making decisions regarding the health of the public as a whole, develop procedures which require only minimal input from those whose primary interest is in the private practice of medicine. The lack of interest in public health issues was reflected in the small number of those attending the Public Health Committee meeting in October of 1979. This lack of interest was manifest in both the Department of Human Resources members and the members from the private sector.

At the October, 1979, meeting of the Public Health Committee, which was designed as an organizational meeting, three current projects were dealt with:

(1) An attempt was made to maintain a high level of child immunizations in the private sector by making available a postcard to notify private patients of immunization needs. These postcards are available on request from the Department of Human Resources (DHR), and are to remind families of the immunization needs existing within that family. The cards are designed to be sent from the personal physician.
(2) The second project made known to the private practicing physician is the availability and type of flu vaccine and the requirements for requisitioning free vaccines from the DHR.
(3) A third area of concern of the committee was the lack of health requirements in day-care centers. There are apparently no required immunizations for those attending day care centers, and these children represent a large and growing population of potentially unimmunized children. The committee still has this matter under investigation.

Part of the charge to this committee was to provide a two-way conduit for the exchange of information between DHR and MAG. The committee feels that it would be a benefit to MAG if the larger county medical societies would establish a committee on public health to deal with local public health issues. It was also recommended that county medical societies ask the county health officer within the area to give monthly, or at least quarterly, reports to the county society. It was felt that these two measures would help develop more adequate communication between the public and the private health care sector.

RECOMMENDATIONS

(1) County societies, where feasible, appoint a public health committee to oversee public health activities in the counties.
(2) County health officers be requested to report local activities to county societies on a regular basis.
(3) MAG make a formal request to the new commissioner of DHR when he is appointed, asking for enhanced communication between MAG and DHR at the highest level.

REFERENCE COMMITTEE DISCUSSION

The recommendations of the Public Health Committee ask for the appointment of a public health committee by each county society where feasible; that county health officers regularly report local activities to the county societies; and that the MAG make a formal request to the new commissioner of DHR asking for enhanced communication between MAG and DHR at the highest level.

The report of the Public Health Committee outlines the major concerns discussed by the committee since its creation last year. These concerns are the need to maintain a high level of child immunizations in the private sector, the availability of flu vaccine to the private, practicing physician, and the requiring of immunizations for children in day-care centers.

A new concern is raised in the committee's report — the need for committees on public health within larger county medical societies. The committee believes that local public health committees, as well as regular reports from county health officers to local medical societies, will help to improve communication between the public and private health care sector.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee advises that recommendations 1 and 2 be adopted.

Mr. Speaker, your Reference Committee recommends the adoption of Recommendation 3 as amended by deletion of the words "when he is appointed."

HOUSE OF DELEGATES ACTION

Recommendations 1 and 2 of the Public Health Committee were adopted. Recommendation 3 was adopted as amended by the Reference Committee.

RESOLUTION 3
FINANCE CHARGE FOR MEDICAL BILLINGS

Stephen Boyle, M.D.

WHEREAS, present money costs have escalated anywhere from 12-18% a year and,

WHEREAS, accounts receivables now lose their value at the approximate rate of 1-1½% a month, therefore, be it

RESOLVED, that the MAG go on record in favor of the use of a finance charge on medical bills over 30 days of age.



Theme for National Volunteer Blood Donor Month . . . and for the future.

REFERENCE COMMITTEE DISCUSSION

Resolution 3 asks that the MAG go on record in favor of the use of a finance charge on medical bills over 30 days of age.

Your Reference Committee considered carefully this Resolution and its effects on the practice of medicine. Your Reference Committee notes that the AMA's *Judicial Opinions,* Section 4.31, advises against the medical profession charging interest on the unpaid portions of medical bills. Furthermore, the Section advises against any type of penalty fee or collection fee if bills are unpaid. The *Judicial Opinions* does note that it is not improper for a physician to add a service charge equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable period of time.

The adoption of such a policy is inflationary and not consistent with the overall goals of the Voluntary Effort now being successfully waged by the private sector to keep medical costs to a minimum and maintain the private practice of medicine. The Chairman of the Public Relations Committee presented testimony that a policy supporting interest charges on medical bills would conflict with the current MAG campaign on the Voluntary Effort and would have adverse effects on the public's view of medicine.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 3 be not adopted.

HOUSE OF DELEGATES ACTION

Resolution 3 was not adopted.

RESOLUTION 4
HEALTH AND SAFETY OF HIGH SCHOOL ATHLETES IN THE STATE OF GEORGIA

Floyd-Polk-Chattooga Medical Society

WHEREAS, the physicians of the Floyd, Polk, Chattooga Medical Society are professionally concerned with the health and safety of high school athletes in the State of Georgia, as well as the promotion and encouragement of their athletic competition and physical training, and

WHEREAS, it is felt that all training programs and techniques of athletic development should be done with a careful regard for the normal growth and development patterns of teenagers, and

WHEREAS, the practice of encouraging and tolerating the restriction of dietary intake that is critical to normal growth and development in this age group for the express purpose of arriving at a lower body weight in high school wrestling competition is widespread, and

WHEREAS, no rules exist within the framework of the Georgia High School Association (GHSA) which in any way restricts or regulates the degree of variance from normal weight to which a participant may extend his weight changes, and

WHEREAS, not only the physicians of this Society but of the entire State of Georgia should both condemn and be seriously concerned about the medical hazards of the radical and dangerous practices utilized in this sport to achieve abnormal and inordinately large amounts of body weight loss,

RESOLVED, that the MAG should advise both the State Department of Education and the GHSA of the hazards posed to the health of young wrestlers by this unregulated practice and recommend to them that rules be formulated, applied, and enforced, regarding weight variations for athletic competition.

REFERENCE COMMITTEE DISCUSSION

Resolution 4 asks that the MAG advise the State Department of Education and the Georgia High School Athletic Association (GHSAA) of the hazards posed to the health of high school wrestlers by the unregulated practice of restricting dietary intake for the purpose of rapid weight loss. The resolution also asks that MAG recommend to these organizations that rules be formulated, applied, and enforced regarding weight variations for athletic competition.

Much of the testimony expressed concern with other young athletes in addition to high school wrestlers in which rapid weight reduction practices are common. This indicates the problem is more widespread than the original resolution suggests.

The Reference Committee offers the following amendment by substitution for the RESOLVE in Resolution 4:

"RESOLVED, that, through the MAG Committee on Medical Aspects of Sports, the MAG advise the State Department of Education, GHSAA, and other appropriate organizations concerned with student athletics of the hazards posed to the health of young athletes by unregulated practices of rapid metabolic changes and recommend that appropriate rules be formulated and enforced to protect the health of young athletes."

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends adoption of Resolution 4 as amended.

HOUSE OF DELEGATES ACTION

Resolution 4 was adopted as amended by the Reference Committee.

RESOLUTION 17 CATASTROPHIC HEALTH INSURANCE

W. Daniel Jordan, M.D.

WHEREAS, the MAG has previously stated its opposition to federally mandated catastrophic health insurance, and

WHEREAS, HR 6405, recently introduced into the U.S. House of Representatives embodies the above concept, therefore, be it

RESOLVED, that the MAG reaffirms its opposition to federally mandated and controlled catastrophic health insurance and specifically HR 6405, and be it further

RESOLVED, that the MAG communicate this opposition to the various representatives from the State of Georgia, urging them to be in opposition to HR 6405 and to the above concept.

REFERENCE COMMITTEE DISCUSSION

Resolution 17 asks that the MAG reaffirm its opposition to federally mandated and controlled catastrophic health insurance and specifically to HR 6405 and that MAG communicate this opposition to Georgia's various representatives, urging them to oppose passage of HR 6405.

The Reference Committee notes that the House of Delegates of the MAG adopted in 1979 its position opposing any federally mandated and controlled catastrophic health insurance plan. Your Reference Committee recognizes that this resolution is consistent with current MAG policy adopted by the House of Delegates in 1979. This policy recognizes the need for *voluntary* catastrophic health insurance administered on a state-by-state basis.

Mr. Speaker, your Reference Committee amends the first resolve of Resolution 17 to read: "RESOLVED, that the MAG reaffirms its opposition to federally mandated and controlled catastrophic health insurance and specifically opposes HR 6405."

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee advises the adoption of Resolution 17 as amended.

HOUSE OF DELEGATES ACTION

The House of Delegates adopted a new resolve to be inserted as the first resolve of the Resolution to read, "RESOLVED, that MAG reaffirms its previous position recognizing the need for voluntary catastrophic health insurance administered on a state-by-state basis."

The House then adopted the first resolve of the original resolution and amended by the Reference Committee. The House adopted the second resolve of the original resolution.

COMMITTEE ON THIRD PARTY RELATIONS

Charles D. Hollis Jr., M.D., Chairman

INTRODUCTION

The Committee on Third Party Relations met twice in the year, and both meetings were well attended by committee members. Representatives from Prudential Medicare, from the Georgia Department of Medical Assistance, and from private insurance carriers were invited and provided valuable input as consultants.

The most significant matters under consideration included a proposal for revising and making more equitable the method of physician reimbursement under Medicaid, a voluntary second opinion study by the Metropolitan Life Insurance Company with the cooperation of the MAG, and proposed legislation mandating adequate insurance coverage by all companies for appropriate surgery rendered in an outpatient setting. Information was received regarding further adoption of the CPT-4 coding system by Prudential Medicare and by Blue Shield of Columbus, limitations placed on routine diagnostic hospital admission testing, payment for outpatient laboratory procedures, and the setting of parameters as to the maximum frequency of various outpatient testing procedures allowed under Medicare.

MEDICAID

Problems in the present reimbursement system under Georgia Medicaid were further identified. It was learned that the fee profiles of physicians practicing under Medicaid prior to 1973 were frozen at the 1973-74 levels. Young physicians entering practice since 1973 were allowed payments based upon statewide prevailing charges, and were thus compensated at a level significantly greater than physicians in practice prior to 1973. The



Reference Committee C members (L-R): Drs. John F. Atha, Rockmart; E. M. ("Mac") Molnar, Columbus, Vice-Chairman; Ronald F. Galloway, Augusta, Chairman; Keith A. Quarterman, Jr., Atlanta; and Charles J. Rey, Jr., Austell; and MAG Staff person, Miss Dorothy Parker. Not shown are Dr. Charles R. Richardson, Statesboro, and MAG Staff Bert Franco.

system of dividing the state into four regions for reimbursement purposes also penalized the practitioners in rural areas as compared to those in more metropolitan areas. There also were inequities in payment for the same procedures done by physicians in different specialties.

For several years, the Department of Health, Education, and Welfare (HEW) used the principle of geographic regionalization and fee profiles in its method of determining reimbursement levels under government programs. For this reason, it was rather difficult to devise a reimbursement method acceptable to HEW that would correct these inequities. However, the Georgia Department of Medical Assistance (DMA), with efforts first instituted during the tenure of Medicaid Commissioner David Poythress and continued under the administration of Commissioner Charles Pierce, developed a method which apparently will be acceptable to HEW. The new method will abolish the profile system and geographic distinctions in calculating reimbursement under Medicaid. A statewide system of maximum allowable payment will be instituted, abolishing differences based on medical specialty and location of practice. It is estimated that under the new system, between 40 and 50% of the state's physicians will be paid their full charge for each procedure. Most physicians will realize some increase in their Medicaid reimbusement, since payments generally have been frozen at the 1973 to 1974 level. Some physicians whose charges currently exceed what most other physicians charge will receive some reduction in their payment for specific procedures. However, even some of these physicians may have an increase in overall reimbursement from Medicaid.

The DMA will use a relative value schedule to compare charge levels in Georgia with those in other states of similar demographic characteristics, such as Washington. If charges for any particular specialty fall significantly outside the range shown to be prevalent in similar states, these particular specialties will be asked to discuss their charge levels with representatives of the MAG and with representatives of the DMA in an effort to rectify the differences.

The 1980 Georgia General Assembly appropriated an additional $2.7 million to the DMA in order to implement this more equitable system of physician reimbursement which will update fees generally from the 1973 level. This appropriation had strong support from Governor Busbee, administration leaders, and MAG. Since Medicaid is a government program, it was widely felt that payment for services should be made equitably throughout the state. This payment should be made fairly to physicians who care for patients who otherwise might not be able to obtain quality medical care because of unfair reimbursement to physicians in certain areas.

VOLUNTARY SECOND OPINION STUDY PROGRAM UNDER THE METROPOLITAN LIFE INSURANCE COMPANY

The Metropolitan Life Insurance Company asked MAG to endorse their study of voluntary second opinion projects. This study will involve only major group insurance clients, many of whom had requested such a study. The second opinion is totally voluntary on the part of the patient; there will not be a closed panel of physician consultants; and MAG will be allowed to comment on any information transmitted to patients and will study any of the data before reports on the project are released. As originally agreed with Metropolitan, consultants for the second opinion will be the choice of the patient, the patient's physician, the county medical society, or the group employer selecting a consultant from the MAG roster. If necessary, MAG will be consulted directly regarding the selection of appropriate consultants.

The Third Party Relations Committee voted to approve this study and to recommend that the MAG Board of Directors endorse this voluntary effort by the Metropolitan Life Insurance Company. At its January, 1980, meeting, the MAG Board of Directors agreed to endorse the study and cooperate with Metropolitan.

The study conforms with previously established MAG criteria for second opinion programs as follows:

1. The second opinion is totally voluntary on the part of the patient.
2. No predetermined criteria are established for physicians rendering a second opinion or performing the surgery.

3. There is no closed panel of consultants.
4. The usual and customary fee is paid for a second opinion when rendered.
5. Reimbursement for surgery is not based on the results of the second opinion.

The Metropolitan Life Insurance Company seems to believe, as do most people who have reviewed second opinion projects, that there is little likelihood that second opinion programs will be cost effective. However, market pressures require that larger insurance companies offer some sort of second opinion program to some of their larger subscribers. It is possible that previously unavailable data confirming the high standards of medical care practiced in the United States might emerge from the Metropolitan study.

OUTPATIENT SURGERY

The 1980 Georgia General Assembly passed Senate Bill (SB) 217, requiring insurance companies to provide adequate payment for surgical procedures performed on an outpatient basis. The Third Party Relations Committee voted to withhold support from such legislation, because it felt that voluntary efforts were being made and were likely to accomplish the same results desired from the senate bill without mandating such insurance by law. The committee philosophically believed that it was a mistake to embrace any kind of mandated coverage by insurance companies, since this would tend to open the door for other groups to require coverage for their services. However, the MAG Board of Directors endorsed the concept of SB 217, and the bill did pass.

Modifications in the bill provide that the Georgia Insurance Commissioner, in consultation with appropriate groups within the MAG, will identify the procedures which can reasonably be performed on an outpatient basis. The bill also provides that the Insurance Commissioner may utilize the services of the Georgia Medical Care Foundation in establishing quality assurance for outpatient procedures. The Georgia Medical Care Foundation has agreed to review claims submitted to it for services performed on an outpatient basis. The legislation also specifies that outpatient coverage will be required only for new individual health insurance policies and not for existing individual or group policies.

INFORMATIONAL ITEMS

1. Medicare has proceeded with its principle of paying for laboratory procedures only at the twenty-fifth percentile of charges for similar procedures throughout the state.
2. Medicare has also established parameters which it considers appropriate as to the frequency of certain outpatient tests and procedures. Without accompanying data justifying more frequent tests, Medicare will not reimburse for tests or procedures done more frequently than the arbitrary limits established.
3. Part A Medicare will not reimburse for routine hospital admission tests done outside the hospital prior to admission. This decision makes preadmission testing somewhat of a problem. Reimbursement under Part B requires a co-payment from the patient.
4. The Health Care Financing Administration — the agency now supervising the Medicare and Medicaid Programs — has adopted the procedure code based on AMA's CPT-IV. Blue Cross of Columbus is also in the process of changing over to the CPT-IV procedure code. The Third Party Relations Committee would like to urge physicians again to use the CPT-IV code in submitting all insurance claims. This allows for a much clearer definition of services rendered, minimizes errors in submitting the claims, and speeds up processing time. Physicians should receive payment sooner as a result of this change. At this point only about 25% of the physicians in Georgia are coding their services on insurance claim forms.
5. The Health Care Financing Administration also announced that later this year it will begin using the uniform claim form as developed by the AMA, the HIAA, and the Blues. It will phase out its current Medicare form. This should simplify billing since the uniform claim form can be used for all carriers except Medicaid.
6. Paper-less claims processing is proceeding and is now being used by many hospitals. At present this is done on a tape-to-tape basis from computer terminals in the various hospitals to the computer terminals in the carriers' offices. A few physicians are beginning to utilize this method of submitting claims, thus simplifying the billing process and minimizing the number of errors. It is anticipated that within the next year or so it will be possible for physicians to submit claims over telephone wires directly to computers, and this innovation is certain to be adopted by the Blues and other private carriers. Medicaid already has this capability, and Medicare may also start to use it.

RECOMMENDATIONS

None.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON THIRD PARTY RELATIONS

Charles D. Hollis Jr., M.D., Chairman

The Third Party Relations Committee has worked with the Department of Medical Assistance (DMA) for several years in a variety of activities. These activities have included the revison of the (Medicaid) Physician Provider Manual, the implementation of a new fee system, and improvement in the administration and processing of claims in the Medicaid Program.

On June 6, 1979, the DMA issued its revised version of Part I of the Physician Provider Manual. This portion of the manual covers general administrative procedures within the DMA as applicable to all providers, i.e., physicians, hospitals, nursing homes, ambulance services, etc. In response to this correspondence, the Third Party Relations Committee established a sub-committee to review the Physician Provider Manual. This sub-committee is chaired by A. A. McNeill, M.D., Camilla. Three issues in particular in Part I of the Provider Manual were of concern to the MAG. These concerns regarded addresses

to which Medicaid claims were mailed; appeals procedures in the department; and clarification on record keeping regulations. These matters were brought to the attention of the MAG Board of Directors in September 1979 which endorsed the concerns outlined by the committee. Representatives of MAG met with representatives from the DMA on two occasions, one of which included legal counsel from MAG. The initial concerns in Part I of this manual have been addressed by the DMA. This new Part I, however, is currently not in effect for physicians, and will not be in effect until the DMA issues its completely revised Medicaid Physician Provider Manual which applies specifically to physicians.

The DMA has indicated that it intends to revise the physician portion of the Medicaid Manual. This has been under consideration for several months, but has not taken place as a result of the DMA's efforts devoted to revising the method for reimbursing physicians. This revision of the method of reimbursement received a very high priority within the DMA and has consumed most of the Department's time with regard to physician participation in the program.

The Committee on Third Party Relations intends to pursue the negotiations with the DMA on the specific points involving the revised method for reimbursement and on the Physician Provider Manual in general once it is issued in its revised form. The committee has been informed that the DMA plans to issue its revised Physician Manual after the beginning of the new fiscal year starting July 1. This revision will be issued only once the DMA has completed the implementation of the new Medicaid reimbursement system.

The committee believes that it is in the MAG's best interest to work on the Physician Provider Manual once the revised reimbursement method has been implemented. In this way the DMA and the committee can concentrate their efforts on these revisions and will not be diverted by discussions on the reimbursement system. The committee intends to urge the DMA to revise this manual as soon as possible so that the Medicaid System will be as attractive as possible to physicians interested in participating in it.

The Committee on Third Party Relations has identified three general areas in the Provider Manual requiring attention.

(1) Enrollment and Participation Policy, in particular the "Statement of Participation."
(2) Reimbursement Policies relating to procedures which require prior approval and/or medical reimbursement limitations and the procedures used to determine applicability of these policies.
(3) Grounds for Adverse Action, including the sections relating to Sanctions and Appeals.

However, the committee asks that physicians inform the committee of their concerns about specific sections of the manual which discourage their involvement in Medicaid. In this way, the committee can negotiate specific sections of the manual opposed by members of the MAG. We will present this list of concerns to DMA before it issues its revised manual, thereby enabling DMA to focus on those aspects which discourage physician participation in the Medicaid Program.

The committee would like to make a preliminary report at the September Board Meeting on its progress in revising the Physician Provider Manual. This progress will depend to some extent on DMA's timetable for revision of the manual.

RECOMMENDATIONS

(1) That the House of Delegates direct its members and the remaining members of the MAG to communicate in a timely manner to the Committee on Third Party Relations those specific concerns about the Medicaid Physician Provider Manual discouraging their participation in the Medicaid Program.
(2) That this Supplemental Report of the Committee on Third Party Relations be mailed to all county medical societies to inform them of the progress being made in revising the Medicaid Physician Provider Manual.

REFERENCE COMMITTEE DISCUSSION

The Report and Supplemental Report of the Committee on Third Party Relations, Resolution 2, Resolution 13, and Resolution 14 all deal with the administration of the Medicare and Medicaid Programs in Georgia. As these items of business are interrelated, testimony was heard in concert on all these items. However, because of the interest among the MAG membership in these items, they will be discussed separately for consideration by the House.

The Supplemental Report of the Committee on Third Party Relations asks that the members of this House and remaining members of MAG inform the committee of their specific concerns with the Medicaid Physician Provider Manual. The report also asks that the committee mail the Supplemental Report to the county medical societies to inform them of the current status of negotiations on revising the Medicaid Physician Provider Manual. The report outlines the status of these negotiations and presents a plan for achieving the revision of the Provider Manual. Testimony was heard from the Chairman of the Committee on Third Party Relations that the efforts of the Committee and the Georgia DMA have focused on the revised reimbursement method for Medicaid and once this issue has been resolved, negotiations will resume on the Medicaid Manual.

Your Reference Committee wishes to commend the Committee on Third Party Relations on its diligent efforts in the past several years to bring about changes in the reimbursement methods used by public third party payors. Your Reference Committee recognizes their accomplishments and outstanding ability to carry out the wishes of this organization.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends the adoption of Recommendations 1 and 2 of the Supplemental Report of the Committee on Third Party Relations.

HOUSE OF DELEGATES ACTION

Adopted Recommendations 1 and 2 of the Supplemental Report of the Committee on Third Party Relations.

RESOLUTION 2
MEDICAID COMPLAINTS

South Georgia Medical Society

WHEREAS, the members of the South Georgia Medical Society have experienced consistent and repeated problems with insufficient and delayed reimbursement from the Georgia Department of Medical Assistance (DMA), and

WHEREAS, inquiries to the Georgia DMA concerning these problems are inadequately and infrequently dealt with in a proper and responsible manner by the DMA, and

WHEREAS, the exact extent of these problems among the members of the South Georgia Medical Society and the MAG as a whole may be severe and extensive, now, therefore, be it

RESOLVED, that the MAG increase as necessary its efforts to assist its members in resolving problems with the Georgia DMA and that the membership of the MAG be informed of the availability of this assistance, and be it

RESOLVED, that the MAG membership inform MAG staff of problems encountered in working with the Georgia DMA so that these problems may be dealt with directly and without undue delay, and be it

RESOLVED, that the MAG ask its Committee on Third Party Relations to determine the extent to which reimbursement by the Georgia DMA to MAG members is both untimely and insufficient, and to determine the extent to which the DMA fails to resolve these problems when brought to its attention by MAG members, and be it

RESOLVED, that the Committee on Third Party Relations report back its findings to the MAG Executive Committee for further action.

REFERENCE COMMITTEE DISCUSSION

Resolution 2 asks that the MAG increase as necessary its efforts to assist its members in resolving problems of reimbursement with the Georgia (DMA) and that the membership be informed of this assistance. The resolution also asks that MAG staff be informed of problems MAG members encounter with DMA. In addition, the resolution asks the Committee on Third Party Relations to determine the extent to which DMA does not resolve these problems when notified. Finally, the Committee on Third Party Relations is directed to report back its findings to the Executive Committee.

Your Reference Committee heard testimony on the current problems facing Georgia's physicians with regard to Medicaid reimbursement. It was pointed out that many of these problems result from inadequate handling of claims by the DMA and to some extent from the improper completing and filing of claims by physicians. As a result of these factors, physicians testifying pointed out the need for staff assistance from the MAG to help MAG members resolve these shortcomings in the Medicaid Program. Your Reference Committee points out that the new system of Medicaid reimbursement will help to identify the extent to which Medicaid reimbursement is insufficient and may assist MAG in this regard.



The Past and Present Presidents (L-R): Earnest C. Atkins, Atlanta, and H. Hilt Hammett, Jr., LaGrange.

Your Reference Committee believes that these difficulties experienced by Georgia physicians warrant the full attention of the MAG.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends the adoption of Resolution 2.

HOUSE OF DELEGATES ACTION

Adopted Resolution 2.

RESOLUTION 13
REIMBURSEMENT BY THIRD PARTY PAYMENT AGENCIES

Hall County Medical Society

WHEREAS, existing law permits inequitable and discriminatory reimbursement by third party payment agencies, including Medicaid and Medicare, for services provided by equally qualified but geographically separate physicians, and

WHEREAS, this discriminatory practice disadvantageously affects not only physicians but also patients in non-metropolitan communities, and

WHEREAS, this discrimination is not founded on or ameliorated by differential levels of participation by physicians in state taxation or federal taxation or malpractice insurance premium rates, and

WHEREAS, this discrimination is not founded on or ameliorated by differential levels of participation by patients in state taxation or federal taxation, and

WHEREAS, this differential reimbursement is not justifiable in terms of proportionality to the quality of health care delivered, and

WHEREAS, the disparity in reimbursement for services rendered in metropolitan and non-metropolitan health care centers will have the effect of discouraging the

location of physicians in non-metropolitan areas; therefore, be it

RESOLVED, that the MAG direct its officers, directors, and appropriate committees to work with any and all appropriate agencies to examine and rectify the inequities that exist in third party reimbursement, including Medicaid and Medicare, according to geographical distribution of patients and providers, and be it further

RESOLVED, that the MAG direct its officers, directors, and appropriate committees to periodically publish the results of these efforts in the official organ of this Association.

REFERENCE COMMITTEE DISCUSSION

Resolution 13 directs the officers, directors, and appropriate committees of the MAG to work with appropriate agencies to examine and rectify geographical inequities in third party reimbursement, including Medicare and Medicaid. The resolution also asks that the appropriate persons or groups in the Association publish periodically in the official organ of the MAG the results of these efforts to rectify these problems.

Your Reference Committee heard testimony on the progress that has been made during the past year in rectifying the inequities in Medicaid reimbursement. The Georgia Department of Medical Assistance has revised its method for calculating reimbursement to physicians. This new method should eliminate fee differentials based on specialty and geographic area, thereby making the program more attractive to the state's physicians. The new method will benefit especially those physicians whose fee profiles were tied to the 1973 levels. This new system of reimbursement is scheduled to be in effect by July 1, 1980.

Your Reference Committee also heard concerns expressed about inequitable Medicare reimbursement. The MAG Committee on Third Party Relations worked for several years to remedy this situation. A detailed study was undertaken to determine if a more equitable reimbursement system could be implemented under Medicare. This study, known as SAW II, resulted in a more complex and stratified system of reimbursement, contrary to the goals of the Association. Additionally, there had been considerable discussion at the national level for legislation dealing with statewide reimbursement schedules. In light of these factors, the 1979 MAG House of Delegates voted not to pursue a revised method for Medicare reimbursement until efforts at the national level could be carried out.

Legislation has not been forthcoming from Washington to address the problem of Medicare reimbursement. In fact, the matter has been referred to the National Institute of Medicine for recommendations regarding new methods for reimbursing physicians under Medicare. In light of these new developments, your Reference Committee believes that renewed efforts may be needed to rectify inequities in Medicare reimbursement in Georgia. The committee also recognizes the need to keep the MAG membership informed of this important activity.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee advises adoption of Resolution 13.

HOUSE OF DELEGATES ACTION

Adopted Resolution 13.

The House also adopted a fourth resolve to read "and be it further RESOLVED, that this Association's delegates to the AMA be instructed to effectuate this change."

RESOLUTION 14
STATUS OF EFFORTS TO REVISE THE MEDICAID PROVIDER'S MANUAL

DeKalb Medical Society

WHEREAS, the 1977 House of Delegates received a report from MAG's Medicaid Negotiating Committee regarding its efforts to revise the Medicaid Provider's Manual, and

WHEREAS, the 1979 House of Delegates voted to continue efforts to negotiate with the Department of Medical Assistance regarding revision of the Medicaid Manual, and

WHEREAS, the Medicaid Provider Manual continues to be a barrier to many physicians willing to participate in the Medicaid program, therefore, be it

RESOLVED, that the Medicaid Negotiating Committee, or the appropriate committee if this committee no longer exists, present a status report on its efforts to revise or eliminate the Medicaid Provider Manual to the next meeting of the MAG Board of Directors and a copy of the report be sent to all county medical societies, and be it further

RESOLVED, that if little or no progress has been made, the committee present its plan for achieving a successful resolution of this problem.

REFERENCE COMMITTEE DISCUSSION

Resolution 14 asks that the appropriate committee of MAG present a status report on its efforts to revise or eliminate the Medicaid Provider Manual to the next meeting of the MAG Board of Directors, with a copy of the report going to all county medical societies. The resolution also asks that if little or no progress has been made in this area, that the committee present its plan for achieving successful resolution of this problem.

Your Reference Committee received with interest the Supplemental Report of the Committee on Third Party Relations. This report addresses the specific concerns in Resolution 14 by presenting a status report on its efforts to revise the Medicaid Physician Provider Manual.

This report also outlines the committee's plan to further revise the manual and recommends that county societies be mailed a copy of the report to inform them of the current efforts in this area.

Reference Committee C

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 14 be referred to the Committee on Third Party Relations.

HOUSE OF DELEGATES ACTION

Adopted Resolution 14.

RESOLUTION 20
REPEAL OF SECTION IN GEORGIA'S WORKER'S COMPENSATION LAWS DEALING WITH THE SELECTION OF PHYSICIANS

F. W. Dowda, M.D.

Be it RESOLVED, that the MAG seek repeal of that segment of the Georgia Worker's Compensation law that allows companies to establish a panel of physicians to whom an injured employee is required to go.

REFERENCE COMMITTEE DISCUSSION

This committee heard testimony on Resolutions 20 and 24 together, since both deal with proposed changes in the Worker's Compensation Law. However, your Reference Committee has considered them as separate resolutions.

Resolution 20 asks, "that the MAG seek repeal of that segment of the Georgia Worker's Compensation Law that allows companies to establish a panel of physicians to whom an injured employee is required to go."

Reasons were given supporting the existence of a panel of physicians, these being that physicians experienced in workers compensation cases may be better able to deal with the unique needs of these patients. However, your Reference Committee feels that such panels may be restrictive of patients' freedom of choice of physicians and feels that more careful study and deliberation of this resolution by the Committee on Occupational Health is indicated.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that this resolution be referred to the Committee on Occupational Health for study and that they make a report to the September 1980 meeting of the MAG Board of Directors.

HOUSE OF DELEGATES ACTION

Adopted the recommendation of the Reference Committee.

RESOLUTION 24
AMENDING SECTION 9, 114-504, SELECTION OF PHYSICIANS UNDER THE GEORGIA WORKER'S COMPENSATION LAW

Bruce C. Newsom, M.D.

WHEREAS, the injured workers of Georgia deserve the best medical care available, and

WHEREAS, Code Title 114 relating to Workers' Compensation as amended by HB 1360 and signed into law in 1978 has certain provisions that are contrary to this premise, and

WHEREAS, the part that allows injured employees to be treated by nonphysicians, to wit: " . . . including any person licensed to practice a healing art and any remedial treatment and care in the State of Georgia, . . . " is not in the best interest of our people, be it,

RESOLVED, that this House of Delegates request the Worker's Compensation Board and the next legislature that Code Title 114 be amended by deleting all reference to "any person licensed to practice a healing art and any remedial treatment and care," and be it further

RESOLVED, that HB 1360, Section 9, 114-504, Selection of Physician, be amended by deleting therefrom in all places where it appears the phrase " . . . including any person licensed to practice a healing art and any remedial treatment and care in the State of Georgia, . . . " so that thereafter it will have no reference or mention of such clause.

REFERENCE COMMITTEE DISCUSSION

Mr. Speaker, Resolution 24 asks for an amendment to the Georgia Worker's Compensation Law which would delete from specified sections all references to the phrase, "any person licensed to practice a healing art and any remedial treatment and care" in Code Title 114, Section 9, 114-504, Selection of Physicians.

The committee heard discussion on the detrimental care which may result from the potential treatment of injured workers by nonphysicians. The committee recognizes the concern for good medical care expressed in the testimony received. However, your Reference Committee believes further study and deliberation on specific language is indicated because of the complex nature of this issue.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that Resolution 24 be referred to the Committee on Occupational Health for further study and that a report be made to the September, 1980, meeting of the MAG Board of Directors.

HOUSE OF DELEGATES ACTION

Adopted the recommendation of the Reference Committee.

Reference Committee C

RESOLUTION 9
EXPANSION OF MEDICAL SCHOOLS

Richmond County Medical Society

WHEREAS, current information indicates the expanded number of physicians being trained in medical schools will produce a potential oversupply in the near future, and

WHEREAS, no information exists that indicates an oversupply of physicians would improve the quality of medical care, therefore be it

RESOLVED, that the MAG encourage both Emory University and the Medical College of Georgia to seriously consider reduction in the student body size of their schools of medicine, and be it further,

RESOLVED, that the MAG go on record as opposing additional schools of medicine in our state until such time as the need for increased numbers of physicians exceeds a capacity of the now existing schools to supply them.

REFERENCE COMMITTEE DISCUSSION

Resolution 9 asks the MAG to encourage both Emory University and the Medical College of Georgia to consider reduction of the student body size of their Schools of Medicine.

Resolution 9 also asks the MAG to oppose additional schools of medicine for the present time until the need for more physicians exceeds the capacity of the now existing schools to supply them.

Testimony was presented to the Reference Committee citing the history of the growth and expansion of medical schools nationally and more specifically in Georgia. Data on current medical school enrollments indicate that the nation is soon to experience a greater number of physicians than is necessary to meet the projected medical needs. HEW has gone on record to discourage these growth patterns and has recommended policies to encourage decreased medical school enrollments for now and the immediate future until the need for further growth can be substantiated. Testimony given by representatives from the School of Medicine of the Medical College of Georgia and others corroborates this situation in Georgia.

Mr. Speaker, your Reference Committee would point out that the training of medical students requires large sums of money. Currently, the federal government is considering a reduction in the funds earmarked for the training of physicians. Your Reference Committee further points out the high costs of establishing a new medical school. Your Reference Committee believes that funds available for physician training should be used in the most effective and efficient manner possible. In light of these factors, your Reference Committee makes the following recommendations:

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends that the two RESOLVES of Resolution 9 be not adopted and that the following substitute RESOLVES drafted by this Committee be adopted:

RESOLVED, that the MAG encourage increased legislative funding of the Board of Regents for the Medical College of Georgia School of Medicine to insure adequate support for those students now enrolled because of low faculty/student ratio, inadequate faculty salary levels and the effects of both on the inhibition of faculty recruitment and retention, and be it further

RESOLVED, that the MAG go on record in support of this increased funding plus the continuation of the efforts at the Emory University School of Medicine and the School of Medicine at Morehouse College, and be it further

RESOLVED, that the MAG go on record as opposing an increased enrollment at the Medical College of Georgia and the development of other medical schools in this state until the adequacy of support of the current existing schools with enrolled and active students is assured.

HOUSE OF DELEGATES ACTION

Adopted the first resolve as amended by deletion of the words "inhibition of."

Adopted the second resolve as amended by deletion of the phrase, "this increased funding plus the continuation of the efforts," and in its place insert the phrase, "increased capitation funding."

Adopted the third resolve of the Reference Committee.

AD-HOC COMMITTEE ON THE PRINCIPLES OF MEDICAL ETHICS

C. Emory Bohler, M.D., Chairman

Your committee has met twice in this year for the purpose of looking into the proposed changes in the AMA Code of Ethics. At our first meeting, James S. Todd, M.D., Chairman of the AMA *ad hoc* committee, shared with us his committee's views on the proposed changes, and why his committee came up with the changes they are presenting to AMA.

Your committee feels that the AMA Judicial Council could revise its pronouncements or opinions dealing with the present Code of Ethics without the necessity for enactment of a new Code. We further feel that if this were done, the new pronouncements and opinions could encompass bioethics and other ethical problems which are not addressed by the new proposed Code.

After considerable discussion and deliberation concerning the proposed, your committee would recommend the following:

1. That the present AMA Code of Ethics be retained.
2. That MAG's delegation to the AMA be instructed to follow this recommendation unless *new evidence* presented to the July AMA House of Delegates dictates, in their wisdom, a different action.

Attached to this report is a copy of the current Principles of Medical Ethics, a copy of the proposed changes, and a copy of the AMA *Ad Hoc* Committee on Medical Ethics report to the AMA House of Delegates, A-79.

Reference Committee C

REFERENCE COMMITTEE DISCUSSION

The report of the *Ad Hoc* Committee on Medical Ethics discusses the proposed AMA Code of Ethics to replace the existing Code in effect since 1957. The report recommends that the present AMA Code of Ethics be retained. The report also recommends that MAG's delegation to the AMA be instructed to follow this recommendation unless *new evidence* presented to the July AMA House of Delegates dictates, in their opinion, a different action.

Your Reference Committee heard considerable testimony on this matter. Almost without exception, the testimony presented supported the recommendation of the MAG *ad hoc* committee to retain the AMA's current Code of Ethics. Your Reference Committee recognizes the circumstances under which the AMA has considered revision of its Code of Ethics and believes the matter to be of the utmost importance to this Association.

Your Reference Committee notes that MAG's *ad hoc* committee has labored over the proposed AMA Code of Ethics to consider carefully the recommended changes in the current Code. The *ad hoc* committee finds several sections of the Proposed Code to be inconsistent with the practice of quality medical care.

Your Reference Committee believes strongly that this Association should support the *ad hoc* Committee's recommendations. We further wish to express our confidence in the ability and judgement of the Georgia delegation to the AMA as it carries out the wishes of our organization.

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Reference Committee recommends the adoption of Recommendations 1 and 2.

HOUSE OF DELEGATES ACTION

Recommendations 1 and 2 of the *Ad Hoc* Committee on the Principles of Medical Ethics were adopted.

Mr. Speaker, this concludes the report of Reference Committee C. Mr. Speaker, your Reference Committee would like to express its appreciation to all who participated in our discussions and deliberations. We also would like to thank Mr. Bert Franco and Ms. Dorothy Parker of the MAG staff for their assistance to our committee.



Speaker L. C. Buchanan, Decatur, again presents Michel A. Glucksman, Brunswick, with the "Annual 'Nit Picker' Award."



Several of MAG's new officers for 1980-81 are sworn in. They are (front row, L-R): Drs. Michel A. Glucksman, Brunswick, as Alternate Director of the Eighth District Medical Society; Harrison L. Rogers, Jr., Atlanta, as an AMA Delegate; L. Newton Turk, III, Atlanta, as President-Elect; Joe C. Stubbs, Valdosta, as Director of the Eighth District Medical Society; J. Dan Bateman, Albany, AMA Delegate; H. Hilt Hammett, Jr., President; (back row L-R): Jack A. Raines, Columbus, Muscogee County Director and Chairman of the Board of Directors; Sammie Dixon, Tifton, as Director of the Second District Medical Society; Bob G. Lanier, Atlanta, as Alternate Director of the Medical Association of Atlanta; E. M. ("Mac") Molnar, Columbus, Muscogee County Alternate Director; William C. Collins, Atlanta, Second Vice-President, and W. Ben Spearman, Alternate Director of the Medical Association of Atlanta.

Final General Session
Sunday, April 27

President Earnest C. Atkins convened the Final Session of the 1980 Annual Business Meeting and expressed his appreciation to the Speakers for their handling of the business for the House of Delegates.

INSTALLATION OF OFFICERS

Dr. Atkins asked the incoming President, the President-Elect, the Directors and Alternate Directors, and the AMA Delegates and Alternates, to assemble in front of the Speakers platform to take the oath of office as follows:

President, H. Hilt Hammett, Jr., LaGrange

President-Elect, L. Newton Turk III, Atlanta

First Vice-President, S. W. Clark, Waycross

Second Vice-President, William C. Collins, Atlanta

AMA Delegates, Harrison L. Rogers, Jr., Atlanta, and J. Daniel Bateman, Albany

AMA Alternate Delegate, W. W. Moore, Atlanta

Second District Director, Sammie Dixon, Tifton; and Alternate Director, Lanny Copeland, Moultrie

Eighth District Director, Joe C. Stubbs, Valdosta; and Alternate Director, Michel A. Glucksman, Brunswick

Dougherty County Director, J. Daniel Bateman, Albany; and Alternate Director, Frank F. Middleton III, Albany

Hall County Director, Henry Jennings, Gainesville; and Alternate Director, John Reed, Gainesville

Medical Association of Atlanta Director, William C. Collins, Atlanta; and Alternate Director, Bob G. Lanier, Atlanta

Muscogee County Director, Jack A. Raines, Columbus; and Alternate Director, E. M. Molnar, Columbus

Sixth District Director, James M. Skinner, Griffin; and Alternate Director, Norman P. Garner, Thomaston

President Atkins administered the oath of office to the assembled new members of the MAG Board of Directors and declared these officers duly installed. Dr. Atkins then passed the gavel and medallion as a symbol of leadership to the incoming President, H. Hilt Hammett Jr.

Dr. Hammett then presented to outgoing President Earnest C. Atkins the MAG President's Pin, a bound set of the *JMAG* encompassing the Atkins' Presidential Year, and a silver gavel appropriately inscribed.

Dr. Hammett announced the date and site of future MAG House of Delegate's meetings as follows:

1981 Callaway Gardens, May 7-10

1982 Savannah, April 23-25, DeSoto Hilton Hotel

1983 Jekyll Island, April 22-24, Holiday Inn



The changing of leadership. Immediate Past-President Earnest C. Atkins (L) hands over the Presidential Gavel to incoming President H. Hilt Hammett, Jr.



As one gesture of appreciation for his year of service as MAG President, Dr. Hammett presents Dr. Atkins with a bound volume of the *Journals* containing his President's Letters for the year of his presidency.

Dr. Hammett announced the official attendance at the 126th Annual Session as follows:

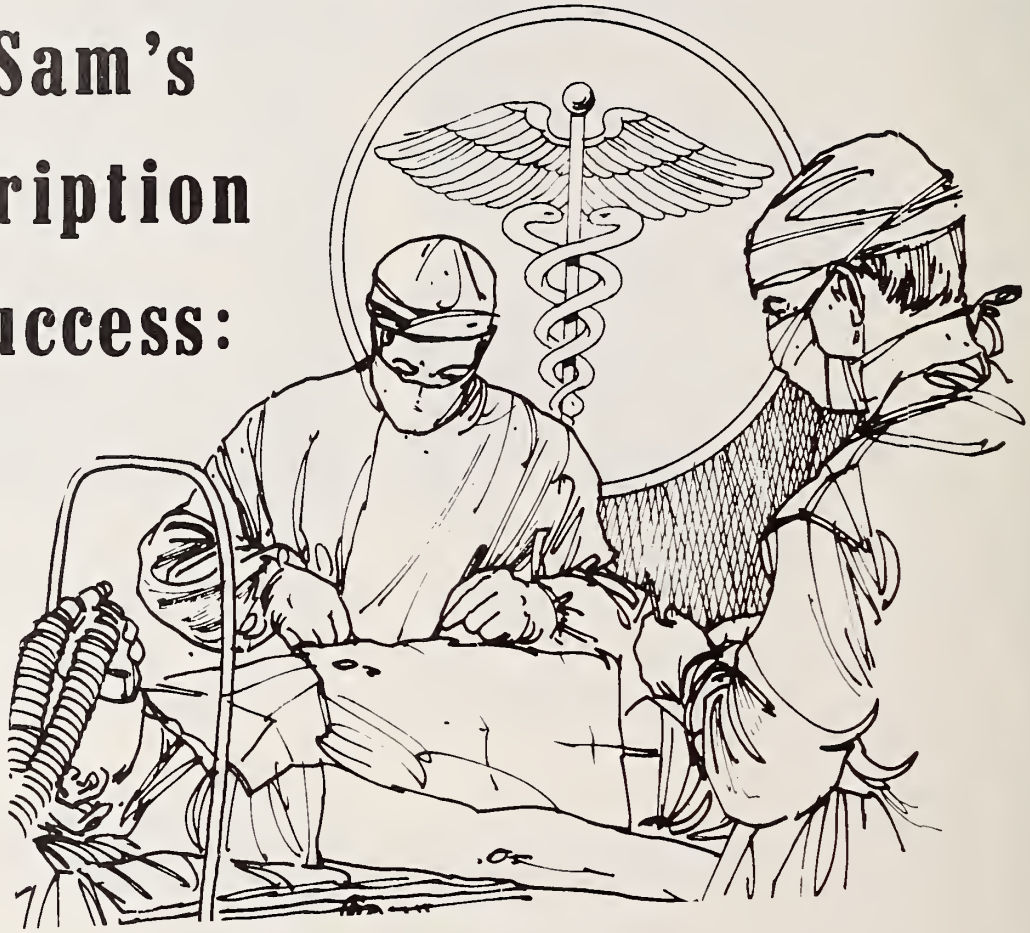
Delegates — 177
Alternate Delegates — 22
Other Members — 17
Guests — 27
Auxiliary — 130

Total Registration — 373

ADJOURNMENT

On motion duly made and seconded, Dr. Hammett adjourned the 126th Annual Business Meeting of the Medical Association of Georgia at 1:25 PM.

Uncle Sam's Prescription For Success:



Medicine and the Ga. National Guard

As a physician in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found...service to community, state and nation.

In addition, many persons have found that the change of place and change of pace have resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for the Georgia Army National Guard units. Physicians receive monetary support for attending approved CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. **WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS.** If you need that **CHANGE OF PLACE** and **CHANGE OF PACE**, contact:

ARMY NATIONAL GUARD
The Guard belongs.

Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662



Tagamet®

brand of

cimetidine

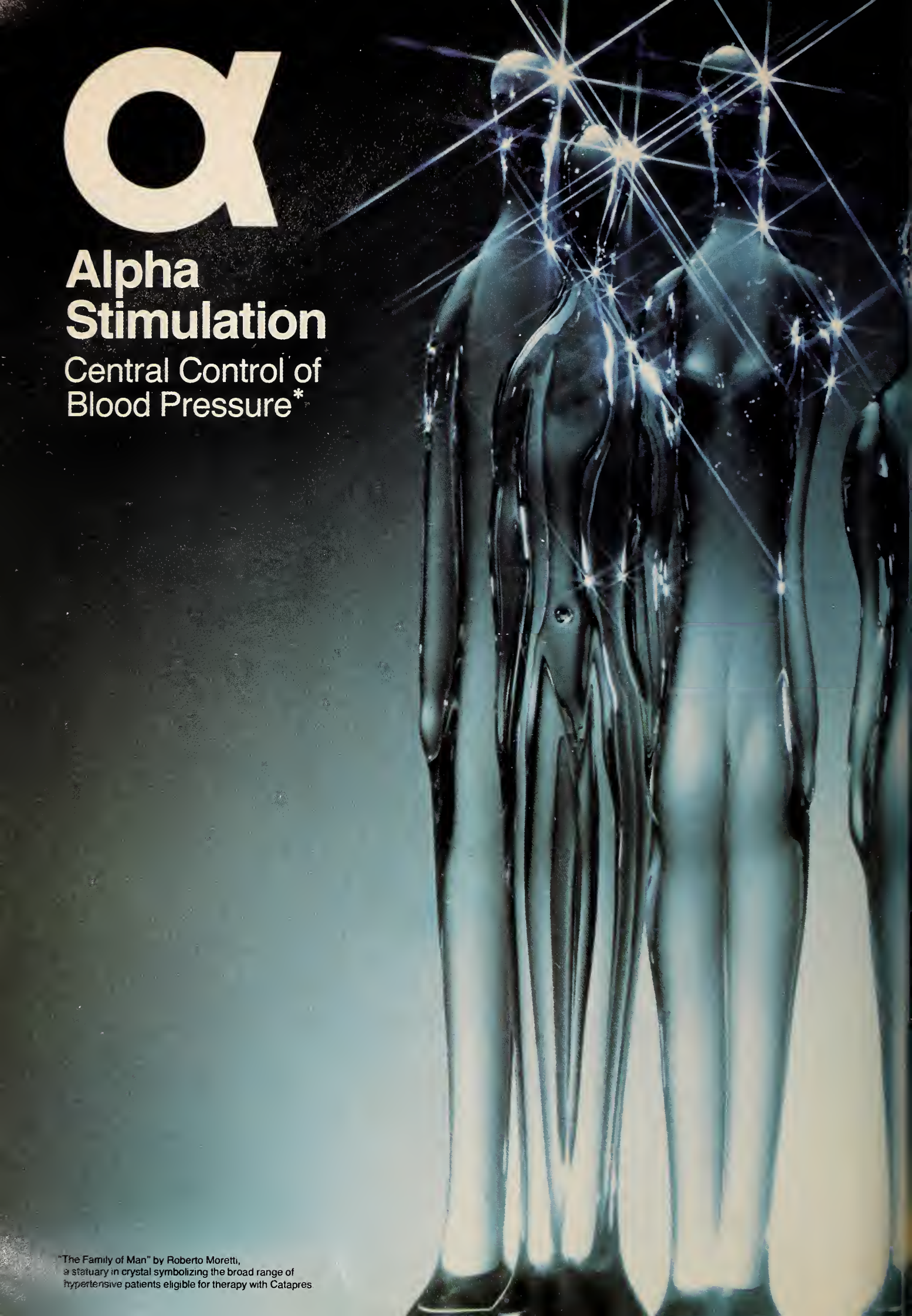
How Supplied:

Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

SK&F LAB CO.
a SmithKline company

Alpha Stimulation

Central Control of Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

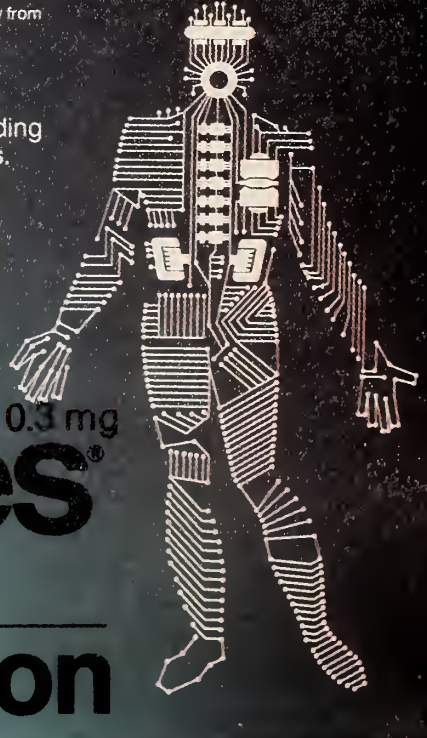
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets



Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension



The Alpha Advantage:

It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochlonde) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

Boehringer Ingelheim
Boehringer Ingelheim Ltd
Ridgefield, CT 06877

Litchfield Hundred

2½ to 6 Acre Homesites in North Fulton County



LITCHFIELD HUNDRED'S 135 homesites are being developed amid the natural beauty of undisturbed forest in North Fulton County. The 650, heavily wooded acres will provide the homeowner with the atmosphere of space and the natural seclusion of a country estate, yet the urban conveniences of Roswell and Atlanta are just minutes away.

DuBose-Jones Co. is committed to the preservation of these natural surroundings through the use of an all underground utility system, including natural gas, and protective covenants which require approval of house design and location on the lot.

Come, walk LITCHFIELD HUNDRED and feel its unique blend of nature, privacy and luxury. **From $25,000—Five year financing.**

DIRECTIONS: North on GA 400. Exit and go west on Holcomb Bridge. Cross Roswell Rd. and turn right on King Rd. (3 Mi). Turn left on Cox Rd. (2 Mi). Entrance is one mile ahead on right.

A development of DuBose-Jones Co.

1401 West Paces Ferry Rd., Suite A-210 • Atlanta, Ga. 30327 • (404) 262-2802

Acceptance Speech H. Hilt Hammett, Jr., M.D., for Office of President of the Medical Association of Georgia



Dr. Hammett

Mr. Speaker, Dr. Atkins, Members of this House of Delegates, Distinguished Guests, Ladies and Gentlemen,

I wish to express my sincere appreciation to the Speaker for affording me this opportunity to address the House at this specific time.

My intent is to present to you my concise and precise position as this organization begins a new year.

It is my sincere hope and request that each of you will relay the essence of my remarks to your respective societies.

I am grateful to be allowed the honor and the privilege of accepting *new* challenges and opportunities on behalf of the Medical Association of Georgia.

The purposes of this Association are to promote the science and art of medicine and the betterment of public health.

Chapter I, Section I of our Bylaws specifically and clearly enumerates and documents these purposes.

My statement to this House of Delegates and to our membership is that I will promote and unqualifiedly support the Constitution and Bylaws of the Medical Association of Georgia.

American medicine accepted the challenge many years ago to provide *quality* health care and to endeavor to make that quality care geographically available to all in need.

I believe that our profession continues to successfully perform to meet that challenge.

I am confident that physicians will continue to support the voluntary effort of cost containment, at the same time providing quality health care. This is necessary and right.

And yet, the diversified positions of American medicine, the private health care industry, and the federal government and congress repetitiously present us with a necessity to realistically assess our attitudes and direction.

The great American tradition is that democracy should allow us the ability to direct our individual destinies while maintaining respect for one's individuality even when proceeding as a society of individuals.

Americans must have the opportunity to believe that freedom and justice are inseparable, that responsibility accompanies privilege, that the individual is the most important element in a free society, that liberty is man's most valuable possession, and that character is the measure of his worth.

It is my contention that the demonstrated intent and direction of our federal government for the past 30 years has been to take away and destroy those principles.

I believe the record precisely documents that position by government towards the profession of medicine.

I do not accept the condemnation of our profession by politicians and governmental bureaucrats. American medicine does not need more bureaus or commissions.

A government that consistently — and I personally contend — deliberately seeks to destroy, rather than preserve incentives and private enterprise, must not be uncontested.

Through agencies such as the Federal Trade Commission, we physicians have been denied due process and have had our first amendment rights violated.

Our profession must continue to be actively involved in the political and socio-economic arenas. This must be done to protect our rights.

Our action must be a consolidated effort to affirm that voluntary professional societies are free to set ethical standards that promote the delivery of quality health care.

The American physician has shown that it is possible on a large scale and by strictly voluntary methods to morally and ethically perform and serve in a successful manner as our patients and our society specifically deserve.

Physicians must focus strong attention on the fact that the key to continued excellence in medical care is the system that allows you to select your own physician, and for your physician to practice medicine without undue and unwarranted legislative restrictions.

We must never forget that government, however necessary, has nothing to give but that which it first takes away.

Government is a consumer and not a producer. But — it applies equally to our profession as well as to our government — that there are no rights without duties, and no privileges without responsibilities.

The dangers of all times are the dangers of apathy and complacency.

There are far too many of our federation of medicine who are too complacent to work, think, and act for medicine.

Nothing at the top can make up for apathy and indolence below.

We should not exercise our rights without performing our responsibilities.

My direction shall be to strengthen our House of Medicine with my undivided willingness to responsibly work and act to protect and promote our rights.

Let the record be clear, concise, and positive.

My position on all vital and important issues will always be direct and open.

I am committed to tireless effort to promote and consolidate progress in all activities within the House of Medicine.

I am irrevocably committed to continue to demand the individual's right to privacy and to the preservation of private patient-physician relationship.

I believe that medicine must continue to vigorously oppose any regulatory action that would restrict or restrain the operation of the free enterprise principle in the delivery of quality health care.

I am committed to cost containment through cost effectiveness by voluntary effort within the mechanism of the free market place.

The Medical Association of Georgia must continue the promotion, expansion, and achievements in the field of medical continuing education.

Unification of our profession within the MAG framework is vitally important. I am committed to that principle to have MAG speak for every doctor of medicine in Georgia.

Quality membership — in unity and in numbers — must be — and will be — among our top priorities.

I am dedicated to quality medical care and service in every component of the health care field.

I pledge to you my dedication, availability, loyalty, and determination to represent the Medical Association of Georgia in a dignified manner. This I believe. This I can do. This I will do.

I respectfully ask for your advice, support, and concern.

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



BMW
THE ULTIMATE DRIVING MACHINE.
BMW, MUNICH, GERMANY

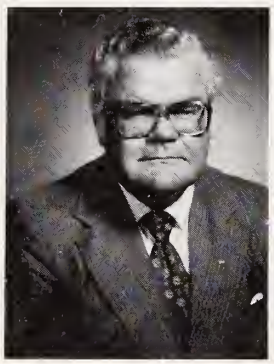
© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS
225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730

editorial
editorial
editorial

An Introduction of the New MAG Officers

The 1980 Annual Business Meeting culminated in the installation of MAG's newly-elected officers. Brief biographical sketches are presented below to acquaint you with the excellent officers who will lead our Association in the coming year.



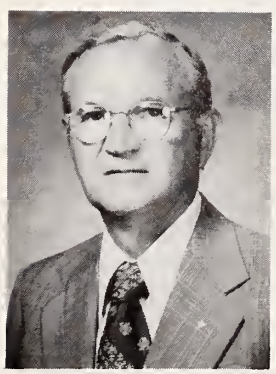
President

Our new president, **H. Hilt Hammett Jr., M.D.,** has served the MAG for several years in various high offices leading up to his presidency. He is also a member of the Board of Directors, and alternate delegate to the AMA. A graduate of Emory University School of Medicine, Dr. Hammett has practiced in LaGrange since 1949. He is a specialist in ophthalmology and otorhinolaryngology. Professionally he is a Fellow of the American College of Surgeons; a Diplomate of the American Board of Otorhinolaryngology and the American Academy of Ophthalmology and Otorhinolaryngology; a former Chief of Staff and current staff member of the West Georgia Medical Center; a past-president of Troup County Medical Society; Immediate Past-Chairman of the Board of Directors of Blue Shield of Georgia/Columbus, Inc.; and a member of numerous medical and specialty societies. He is also an active member of the First Presbyterian Church of LaGrange.



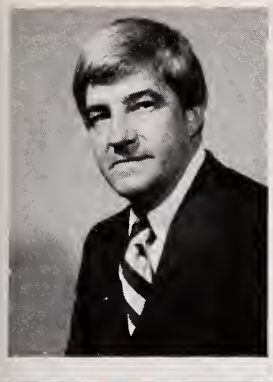
President-Elect

L. Newton Turk III, M.D., a native of Atlanta, practices cardiovascular and thoracic surgery in Atlanta. Dr. Turk earned his M.D. degree from Emory University School of Medicine and received additional training at Yale-New Haven Medical Center and Peter Bent Brigham Hospital in Boston. He has served MAA as its treasurer, president-elect, and president and the MAG as a delegate and vice president. He is a member of numerous professional societies. Dr. Turk has served on the Board of Directors for MAA, Metro Atlanta Foundation for Medical Care, GMCF, and Atlanta Blue Cross/Blue Shield. He is a Fellow in the American College of Surgeons and the American College of Chest Physicians. He is involved as well in several civic and community activities.



First Vice-President

S. William Clark Jr., M.D., practices ophthalmology in Waycross. He received his M.D. degree from Emory University School of Medicine and trained at Grady Hospital in Atlanta. Dr. Clark is a past president of the Ware County Medical Society, the Eighth District Medical Society, and the Georgia Society of Ophthalmology and Otolaryngology. He is also a Delegate to the American Association of Ophthalmology, a Fellow of the American Academy of Ophthalmology, and a Council Member of the Georgia Society of Ophthalmology.



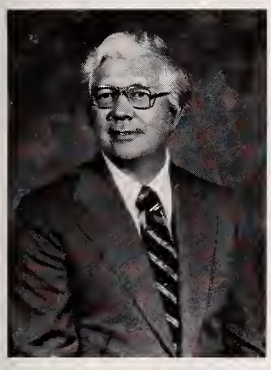
Second Vice-President

Born in Forsyth, **William C. Collins, M.D.,** graduated from the University of Georgia and earned his M.D. degree from the Medical College of Georgia. He practices orthopedic surgery in the Sandy Springs area and has been active in organized medicine for several years. He has served the MAA as its treasurer and president and GaMPAC as its secretary-treasurer and fifth district representative. He also belongs to many other professional organizations. He is on the teaching staff at Scottish Rite Hospital and a clinical professor.



Secretary

William D. Logan Jr., M.D., is a thoracic and cardiovascular surgeon in Atlanta, where he received his M.D. degree from Emory University School of Medicine. Dr. Logan is a past president of the Medical Association of Atlanta and the Atlanta Lung Association. He is on the Board of Governors of the Georgia Chapter, American College of Chest Physicians. He is vice-president of the Southern Thoracic Surgeons Association and Chief of Staff at Georgia Baptist Medical Center.



Treasurer

James H. Sullivan, M.D., a Columbus urologist, received his M.D. degree from the Medical College of Georgia and is also a graduate pharmacist. He is a member of the American Board of Urology and serves on the Board of Directors and Executive Committee of three hospitals in Columbus. Dr. Sullivan is a past president of the Muscogee County Medical Society, vice-chairman of Muscogee County Board of Health, and has served MAG as first vice-president and second vice president. This is his fourth year as treasurer.

president's letter



Strength in Confidence

I BELIEVE there is strength in confidence.

The track record of American medicine gives me confidence that the American people are not dissatisfied with the medical care system in the U.S.A.

I do not accept the condemnation of American medicine by many governmental bureaucrats and politicians.

It is not only immoral but also an indication of a lack of integrity for our government or its agencies to consistently promote tactics that degrade our profession.

American medicine does not need more bureaus and commissions. We accepted the challenge years ago to provide quality service and health care.

What we have is not perfect and never will be.

It just simply is the very best available in the world today.

Our job is to make it more available at the very best economic level without sacrificing quality.

I am confidently optimistic and determined to do my share towards that goal.

The clear challenge remains.

Every one of us must have the confidence to accept the challenge of being both consistently and strongly supportive of our house of medicine.

Why?

Because our house of medicine is the only place where physicians can meet in the interest of common, collective, and individual causes to fulfill our responsibilities to our patients and to our society.

Respectfully,

H. Hilt Hammett Jr., M. D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

NEW MEMBERS

Adams, Daniel M., MAA—ACT—OTO
2719 Felton Dr., East Point 30344

Blount, Wade B., Richmond—N-2—OBG
820 St. Sebastian Way, Augusta 30904

Brueckner, Lawrence T., Gwinnett-Forsyth—ACT—ORS
1300 Plaza Office Park, Ste. 14, Lawrenceville 30245

Clark, Robert B., Jr., Southeast Georgia—N-2—GP/GS
Maple Dr., Vidalia 30474

Drummond, John A., MAA—N-2—IM/ID
35 Collier Rd., NW, Ste. 425, Atlanta 30309

Duque-Dizon, Grace T., Bibb—ACT—AN
77 Hemlock St., Macon 31208

Friberg, Thomas R., Richmond—ACT—OPH
Medical College of Georgia, Augusta 30912

Hatfield, Theodore R., Troup—ACT—OM
P.O. Box 71, West Point 31833

Lennington, B. Richard, Bibb—N-2—R
380 Hospital Dr., Ste. 170, Macon 31201

Lo, Hing-Har, Muscogee—N-2—R/NM
P. O. Box 2787, Columbus 31902

McLeod, Natalie B., Richmond—ACT—NTR
MCG, Faculty Pavilion, Nutrition Section, Ste. 101, Augusta 30912

Morris, Michael D., Bibb—I&R—FP
3741 Houston Ave., Macon 31206

Morris, Richard L., Richmond—ACT—PS
MCG, Plastic Surgery Division, Augusta 30912

Poon, Glenn S. H., Elbert—ACT—FP
33 Chestnut St., Elberton 30635

Rattan, Kamal K., Gwinnett-Forsyth—ACT—ORS
1300 Plaza Office Park, Ste. 14, Lawrenceville 30245

Rundles, William R., Thomas Area—ACT—GS/GP
980-4th St., SE, Cairo 31728

Schlaer, Stephen M., Richmond—ACT—ON
1514 Anthony Rd., Augusta 30904

Schoberg, Thomas W., MAA—N-2—U
340 Boulevard, NE, Ste. 11, Atlanta 30312

Shetty, N. S., Jackson-Banks—ACT—IM/GS
111 Homer St., Commerce 30529

Stefanson, Sturla, Bibb—N-2—AN
777 Hemlock St., Macon 31201

Tan, Mike Y., Clayton-Fayette—ACT—AN
409 Arrowhead Blvd., Bldg. A, Jonesboro 30236

Tran, Chuong D., Richmond—ACT—GP
Georgia Regional Hospital, Augusta 30906

Victor, Jules, III, Georgia Medical Society—N-2—IM/ON
P. O. Box 14359, Savannah 31406

Whitlock, Richard R., Jr., Richmond—ACT—C/IM
MCG, Cardiology Section, Augusta 30912

PERSONALS

First District

Hinesville Mayor James Brown and Liberty County Commission Chairman James Floyd declared April 28 through May 4 as **Whit Fraser** Week. Brown, Floyd, friends, and patients honored Dr. Fraser for "faithful, dedicated, and humanitarian service to the people of Liberty and surrounding counties."

Third District

William K. Harper, M.D., Columbus, has been named a Fellow of the American College of Cardiology.

David Roberts, M.D., Columbus, has been named Attending Physician of the Year by the residents and interns of the Medical Center of central Georgia.

Enis Waldemayer, M.D., Americus, has joined the Family Practice Center Medical Staff in Ellaville.

Fifth District

Fairburn physician, **C. R. Barksdale Jr., M.D.,** retired March 29, 1980, after 25 years of practice. In recognition of his medical contributions to the city, Fairburn Mayor A. J. Green and the city council members adopted a resolution designating March 31 as Dr. C. R. Barksdale Day.

Michael A. Chorches, M.D., of Atlanta, was recently elected chief of medicine at St. Joseph's Hospital.

Sixth District

Michael T. Simpson, M.D., and **James A. Brennan, M.D.,** of LaGrange, have recently been certified with the American Board of Internal Medicine's Subspecialty Board in Cardiovascular Medicine.



Medicine needs doctors who are committed not only to their private practices but also to the public involvement in the political affairs of state and nation. Photo L to R: Dr. James Kaufmann, Dr. Selwyn T. Hartley, Governor George Busbee, Dr. Cassandra Evans, Mr. Wayne Shumann.

Seventh District

Robert J. Alpern, M.D., G. Douglas Talbott, M.D., and **William F. Wieland, M.D.,** Smyrna, spoke at the sixth annual Career Women's Seminar at the World Congress Center in Atlanta. The doctors spoke on some of the pitfalls and pressures that women encounter in the business world.

Raymond Corpe, M.D., director of the tuberculosis unit at Northwest Georgia Regional Hospital in Rome, is one of 75 people in the nation to be selected for the American Lung Association's Hall of Fame.

Richard Hammons, M.D., Austell, was recently chosen by the Cobb County Commissioners to serve on the nine-member Hospital Authority of Cobb General Hospital.

Sidney L. Sellers, M.D., Dalton, was recently recertified as a Diplomate of the American Board of Obstetrics and Gynecology.

F. Jones Smiley, M.D., Ft. Oglethorpe, was recently elected Vice Chief-of-Staff for 1980.

Evan Weisman, M.D., has became a Fellow of the American College of Cardiology.

Tenth District

Robert B. Greenblatt, M.D., Professor Emeritus of the Department of Endocrinology at the Medical College of Georgia, has recently been selected honorary president of the 10th World Congress on Fertility and Sterility to be held in Madrid, Spain, this summer.

SOCIETIES

Rome vascular surgeon, John S. Kirkland, M.D., spoke to the **Gordon County Medical Society** at their March 31 meeting. Dr. Kirkland's subject was "Diagnosis of Carotid Insufficiency."

DEATHS

Edward M. Graves

Edward M. Graves, 53, of Toccoa, died March 14, 1980.

Dr. Graves received his M.D. degree from Bowman Grey School of Medicine in Winston-Salem, N.C., and served his internship at Georgia Baptist Hospital in Atlanta. He began practicing in Toccoa in 1959.

Survivors include his wife, a daughter, two sons, two sisters, and two grandchildren.

Robert H. Bradley

Robert H. Bradley, M.D., 95, died March 17, 1980.

Dr. Bradley practiced medicine in Murray County for 55 years. He was a member of the Murray-Whitfield

County Medical Association, the Medical Association of Georgia, and the American Medical Association. In addition to his medical career, Dr. Bradley served as mayor of Chatsworth from 1938 to 1940 and was a member of the city council from 1944 to 1945.

Survivors include his wife, a daughter, a son, seven grandchildren, and one great-grandchild.

Edna S. Porth

One of Georgia's oldest and most prominent women physicians, Edna S. Porth, M.D., died March 22, 1980, of cancer. She was 71.

Dr. Porth was one of three women graduates of Emory University Medical School in 1949. She served a rotating internship at Piedmont Hospital, with a first year surgical residency at Crawford W. Long Hospital and a second year at Piedmont Hospital. She was appointed to the staff of Piedmont in 1953 where she served until her retirement. She served on the U.R.C. at Piedmont Hospital for 2 years.

Six years ago, Dr. Porth began part-time employment with the Department of Health, Education, and Welfare as a medical consultant. She was a member of the Medical Association of Georgia as well as several other medical organizations.

John Gartner Sharpley

Savannah surgeon, John Gartner Sharpley, M.D., 70, died April 14, 1980.

Dr. Sharpley's medical career began 47 years ago. Born in Savannah, Dr. Sharpley received his medical degree from the University of Georgia Medical School and served his internship at the University Hospital in Augusta. He completed post-graduate work in surgery at the University of Pennsylvania and served as a staff member at Henry Ford Hospital in Detroit in the late 1930s.

During World War II, Dr. Sharpley entered the military as a captain in the Army Air Corps. He was stationed in Warton, England, and participated in the battle at the Ardennes Bulge.

Dr. Sharpley was the chief surgeon of the Central Georgia Railroad and in 1959, became the Chief of Staff of the Central Georgia Hospital, a position he retained until the hospital became Candler Central Hospital. He was on staff at Candler General Hospital, Memorial Medical Center, and St. Joseph's Hospital. He was a fellow of the American College of Surgeons, and a member of the Georgia Medical Society, the American Medical Association, and the Medical Association of Georgia. Dr. Sharpley was also a member of St. Andrew's Episcopal Church.

Survivors include his wife, a daughter, two sons, a sister, a grandchild, and several nieces and nephews.

Marton Majoros

Marton Majoros, M.D., 49, died April 6, 1980.

He was the son-in-law of former DeKalb County Commissioner Tom Callaway, and a member of the Board of Directors of Decatur Hospital.

A nationally-known otorhinolaryngologist, Dr. Majoros had practiced medicine in Atlanta from 1962 until 1977. He was a member of the Triological Society, the American Medical Association, the Medical Association of Georgia, and the Medical Association of Atlanta.

Born in Tokol, Hungary, Dr. Majoros participated in the 1956 Hungarian uprising against the Soviet Union. In December 1956, he escaped to Austria and came to the United States in 1957.

Dr. Majoros graduated cum laude from the University of Budapest School of Medicine and completed his internship and residency in general surgery at Washington (D.C.) Hospital Center. He completed a fellowship in otorhinolaryngology at the Mayo Clinic.

He served on the faculties of Emory University and Georgia Institute of Technology, and was a founding member of West Paces Ferry Hospital.

In addition to his medical career, Dr. Majoros founded Mahun Oil & Gas Corporation in 1974. His success in the business world was highlighted in an article in *Medical Economics*.

He served as Vice-President of the American Hungarian Federation, and was President of the American Hungarian Cultural Association of Georgia in 1974-75.

Dr. Majoros is survived by his wife, a daughter, both parents, two sisters, and a nephew.

John A. Meier

A prominent, retired Albany orthopedic surgeon, John A. Meier, M.D., 58, died April 8, 1980.

Dr. Meier, a native of Blair, Nebraska, had lived in Albany 23 years. He graduated from the University of Nebraska School of Medicine and served in the Navy's medical corps during World War II. He was a surgeon at San Diego General Hospital, Kennedy Hospital, and Hope Haven Crippled Children's Hospital in Jacksonville, Florida, before coming to Albany.

Dr. Meier served on the staffs of Phoebe Putney and Palmyra Park hospitals and served as director of the Crippled Children's Clinic. He also served as a medical director of the Easter Seal Rehabilitation Center for 20 years. He was a member of the Academy of Orthopedic Surgeons, the American Medical Association, the Medical Association of Georgia, and the Dougherty County Medical Society. He was a communicant of St. Patricks Episcopal Church.

Survivors include his wife, three daughters, three sons, his mother, a sister, and a grandson.

In lieu of flowers, memorials may be made to the Easter Seal Society or St. Patricks Episcopal Church.

Index to Advertising

Vol. 69 June 1980 No. 6

Arthritis Foundation 434
Ballard, Walter, Optical Company 467
Boehringer Ingelheim Ltd. 562-564
Boots Pharmaceuticals, Inc. 479-482
Brawner Psychiatric Institute 418
Classifieds 424
The Coca-Cola Company 541
Decatur Hearing Aid Service 417
The Devereux Foundation 439
Dickey-Mangham Company 467
DuBose-Jones 565
Fulton Federal Savings and Loan Association 544
Georgia National Guard 560
Georgia Rehabilitation Center 526
Global Imports 567
The Great Cherokee Trading Company 424
Hickman-Datsun 424
Insurance Corporation of America 468
JMAG Classifieds 507
Lilly, Eli, and Company 426
MAG Scientific Assembly 492
Medseco 430
Metro Ambulance 431
Office Communications, Inc. 470
Ortgega Pharmaceutical Company, Inc. 438
Peachtree and Parkwood Mental Health Center and Hospitals 522
Potter-Holden and Company 417
Psychiatric Institute of Atlanta 520
Recording for the Blind, Inc. 440
Ridgeview Institute 508
Roche Laboratories 466, 467, 575, 576
The Rocker Shop 514
Rorer, William H., Inc. 428-430
Schering Corporation 416, 417
Smith Kline Diagnostics 427
Smith, Kline, & French 561
The Upjohn Company 542-544
Valley Psychiatric Hospital 514
Weight Watchers of Greater Atlanta 507
Willingway Hospital 519
Wyeth Laboratories 531, 532

JOURNAL of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc. to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

JOURNAL
of the medical association of
georgia
ISSN·0025·7028 JULY / 1980

LIBRARY
UCL SAN FRANCISCO
AUG 1 1980

Shell Game on the Potomac

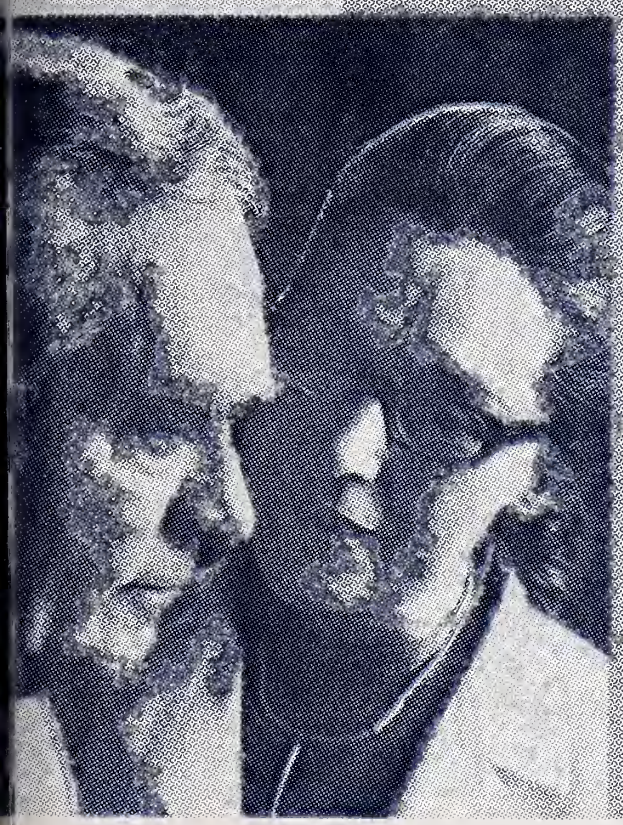
Page 615



proven antianxiet

Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). **And today this promise continues to be fulfilled in a wide variety of patients you see every day.**

ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® IV

chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- An unsurpassed safety record
- Minimal effect on mental acuity, in proper dosage
- Predictable patient response
- Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE Roche Products Inc.
Manati, Puerto Rico 00701

Are you paying taxes on your savings interest again this year?

If so, you need to learn about Fulton Federal's Tax Deferrer. It's a savings plan that lets you defer taxes on your interest until you are in a lower tax bracket. With a minimum deposit of $5,000, your funds will be invested in the highest yield for which your account qualifies.* (There's a small annual service fee, as well as a one-time processing fee.) For more information, call or come by the Fulton Federal branch nearest you.

*A substantial interest penalty is required for early withdrawal.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 • Atlanta, Georgia 30301 • 404-586-7983

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 7

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director and Director of Legislative Activities
Stephen L. Daniel, Ph.D., Assistant Executive Director — Education
J. Tom Sawyer, Assistant Executive Director — Administration
Kenneth M. Williams, Director of Public and Professional Relations
Joyce Butler, R.N., Director of Medical Practice
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

597 *Campylobacter* Enteritis
Carlos E. Lopez, M.D.
Dee Jackson, M.T., A.S.C.P.
609 A Cavitary Lesion in the Lower Lung
Richard B. Stewart, M.D.
Roy M. Waller, III, M.D.

SPECIAL ARTICLES

589 A History of Medicine in Atlanta and Fulton County Part II: Turn of the Century to Treachery
Avalon Woodruff Bryant
601 Appropriateness Review: The Georgia Experience
Jack Bernard

EDITORIALS

615 Shell Game on the Potomac
Robert F. Dee
616 Should MAG Start Its Own Professional Liability Insurance Company?
Charles D. Hollis, Jr., M.D.

FEATURES

621 Legal Page/Using Paraprofessionals as "Expert" Witnesses in Malpractice Cases
Robert N. Berg
629 Cancer Page/Hepatic Resection for Metastatic Colon Carcinoma
Robert Cowgill, M.D.
631 Heart Page/Heart Health Education for the Young, It's Important
Jack E. Birge, M.D.

THE ASSOCIATION

634 President's Letter/ Membership — A Top Priority
H. Hilt Hammett, Jr., M.D.
635 New Members
635 Personals
636 Deaths
636 MAG Physicians Host Georgia Congressmen in Washington, D.C.
639 Physician's Recognition Award Recipients

INCIDENTAL INTELLIGENCE

582 Epidemiologic Note: Dengue Alert for Georgia
585 Medical Meeting Calendar

THE COVER

Who are we to believe, and what are we to believe about the fiscal dilemmas we now face in our country? You can gain some insight into this perplexing problem when you read Mr. Robert F. Dee's editorial on p. 615. He is Chairman of the Board and Chief Executive Officer of the SmithKline Corporation. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

Epidemiologic Note: Dengue Alert for Georgia

The recent introduction of dengue into Mexico is of increasing concern to the 10 southern states at risk for dengue epidemic. The risk of importation is increased because of the common border and the very large number of crossings between residents of our two countries. At the present rate of spread in Mexico, the disease will have reached the border by this time of year. Additionally, both air and overland travel indicate the possibility of significant numbers of citizens of either nation arriving, during the viremic phase, at vulnerable sites far removed from the border itself. Transmission requires a susceptible human population and ample supplies of the vector mosquito. Dengue has not been present since 1945, so we present a highly susceptible population. The vector mosquito is present in sufficient numbers; therefore, all of the Gulf Coast and southeastern states will be at increased risk as the weather warms up this summer.

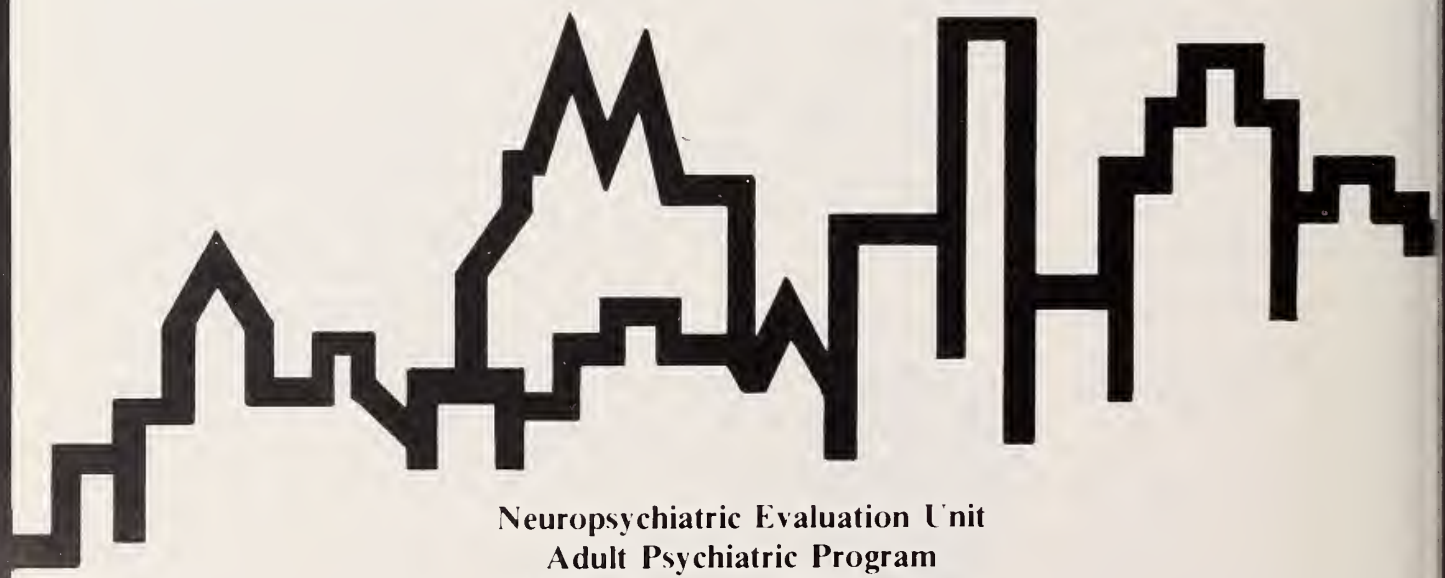
Dengue is caused by a virus of the same group as St. Louis Encephalitis (SLE). While the vector mosquitoes for the two diseases are different, both of them breed and live in close proximity to people. Control of outbreaks is the same, i.e., elimination of breeding sites around homes or work places and use of spray equipment to control adult mosquitoes.

Dengue is an acute, febrile illness caused by infection with one of the four serotypes of dengue virus. In its benign form, it presents with fever, headache, muscle pain, and, often a rubelliform rash (occasionally, petechial). In its malignant (hemorrhagic) form, it is a severe, sometimes fatal disease, characterized by hemorrhagic rash, bleeding into internal organs, and shock. Severity varies from one epidemic to another, but the benign form of disease has predominated in the Western Hemisphere. The period of acute illness is usually 5-7 days, but convalescence can last several times longer. There is no vaccine, and treatment is symptomatic and supportive.

(Reported by the Epidemiology Program, Room 13-H, Georgia Department of Human Resources, Atlanta, GA 30334.)

Psychiatric Institute of Atlanta

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

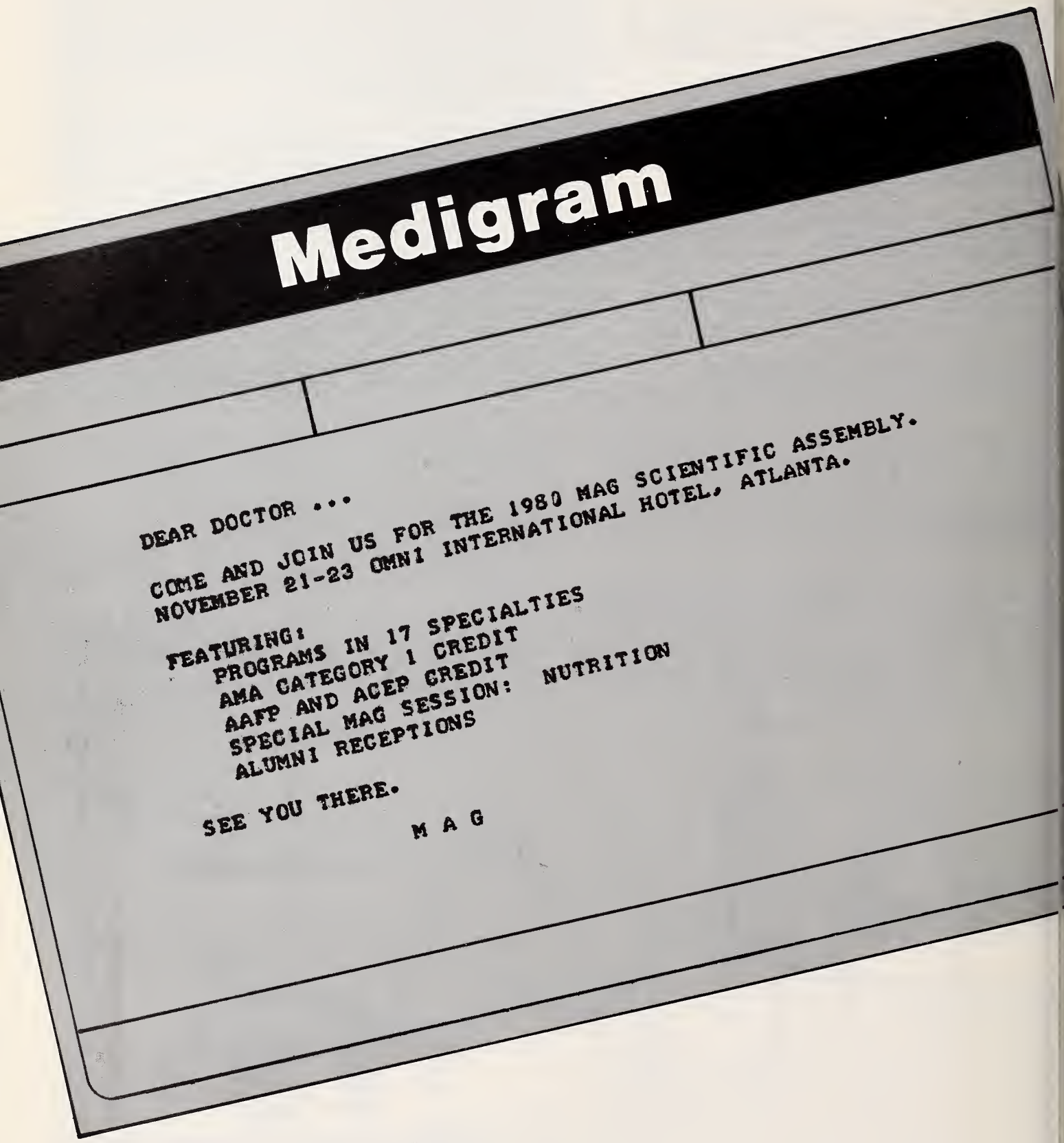
PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals


Medigram
DEAR DOCTOR ...
COME AND JOIN US FOR THE 1980 MAG SCIENTIFIC ASSEMBLY.
NOVEMBER 21-23 OMNI INTERNATIONAL HOTEL, ATLANTA.
FEATURING:
PROGRAMS IN 17 SPECIALTIES
AMA CATEGORY 1 CREDIT
AAFP AND ACEP CREDIT
SPECIAL MAG SESSION: NUTRITION
ALUMNI RECEPTIONS
SEE YOU THERE.
M A G

MEDICAL MEETING CALENDAR

JULY

19-25—*Atlanta;* **American College of Physicians MKSAP V Course:** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

20-25—*Asheville, NC;* **Southern Obstetric & Gynecologic Seminar;** Contact: G. T. Schneider, MD, Ochsner Clinic, 1514 Jefferson Hwy., New Orleans, LA 70121.

22-26—*Hilton Head Island, SC;* **Contemporary Clinical Neurology;** Category 1 credit; Contact: Vanderbilt Univ. CME, 3200 West End, Ste 306, Nashville, TN 37203. PH: 615/322-2716.

27-30—*Hilton Head Island, SC;* **Third Annual Symposium: Nuclear Cardiology for the Practicing Physician;** Category 1 credit; Contact: J. S. Soin, MD, Div. of Nuclear Med., Milwaukee County Medical Complex, 8700 W. Wisconsin Ave., Milwaukee, WI 53226. PH: 414/257-5968.

28-30—*Kiawah Island, SC;* **Pediatrics;** Category 1 credit, Contact: Dr. Gerald T. Chambers, Div. of Cont. Ed., MCG, Augusta, GA 30912. PH: 404/828-3967.

AUGUST

3-7—*Dallas, TX;* **National Medical Association 85th Annual Convention;** Contact: Natl. Med. Assn., 1720 Massachusetts Ave., NW, Washington, D.C.

5-8—*Atlanta;* **International Conference on Nosocomial Infections;** Contact: R. E. Dixon, MD, Hospital Infections Branch, Bacterial Diseases Div., Bureau of Epidemiology, CDC, 1600 Clifton Rd., NE, Atlanta 30333.

11-15—*Atlanta;* **Internal Medicine Board Review;** Category 1 credit; Contact: Daniel M. Smaw, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3525.

11-15—*Atlanta;* **Recent Advances in Internal Medicine;** Category 1 credit; Contact: Daniel M. Smaw, Dept. of Med., Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3525.

21-22—*Birmingham, AL;* **Seminar on Quality Assurance;** Category 1 credit; Contact: Jim Hulett, Alabama Hosp. Assn., Box 17059, East Station, Montgomery, AL 36117. PH: 205/272-8781.

22-23—*Lake Buena Vista, FL;* **EKG Interpretation and Arrhythmia Management;** Category 1 credit; Contact: Internatl. Med. Ed. Corp., Div. of Postgrad. and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

22-24—*Hilton Head, SC;* **Clinical Management of Coronary Disease and Exercise Testing;** Category 1 credit; Contact: Director of CME, Dept. 4, Internatl. Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

SEPTEMBER

18-20—*Sea Island;* **Annual Meeting, Georgia Surgical Society;** Contact: William C. McGarity, MD, Secy.-Treas., GA Surg. Soc., 1365 Clifton Rd., NE, Atlanta 30322.

26-27—*Atlanta;* **Annual Meeting and Scientific Sessions, American Heart Association, Georgia Affiliate;** Category 1 credit; Contact: Ann Angelo, Amer. Heart Assn., GA Affiliate, 2581 Piedmont Rd., NE, Broadview Plaza, Level "C," Atlanta 30324. PH: 404/261-2260.

26-27—*Las Vegas, NV;* **EKG Interpretation and Arrhythmia Management;** Category 1 credit; Contact: Internatl. Med. Ed. Corp., Div. of Postgrad. and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

27-30—*Kansas City, MO;* **Clinical Drug Therapies (AMA);** Category 1 credit; Contact: Frank Chappell, AMA. PH: 312/751-6606 (Office) or 312/644-2426 (Home).

OCTOBER

6-9—*New Orleans, LA;* **32nd Annual AAFP Scientific Assembly.**

10—*Atlanta;* 8th Annual Cardiac Symposium; Contact: Gerald F. Fletcher, MD, Dir. of Internal Med., GA Baptist Hosp., 300 Boulevard, NE, Atlanta 30312. PH: 404/659-4211.

13-14—*Chattanooga, TN;* **Tennessee Valley Medical Assembly;** Contact: F. M. Richardson, Ste 313, 960 E. Third St., Chattanooga, TN 37403.

19-24—*Atlanta;* **66th Annual Clinical Congress of the American College of Surgeons;** Category 1 credit; Contact: Dianne Currie O'Rourke, Mgr. of Public Information, Amer. Coll. Surg., 55 E. Erie St., Chicago, IL 60611. PH: 312/644-4050, ext. 324.

24-26—*Atlanta;* **Clinical Management of Coronary Disease and Exercise Testing;** Category 1 credit; Contact: Internatl. Med. Ed. Corp., Div. of Postgrad. and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

26-30—*Boston, MA;* **46th Annual Scientific Assembly of the American College of Chest Physicians;** Category 1 credit; Contact: Amer. Coll. Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

31-Nov. 2—*Callaway Gardens;* **Pre-Practice Seminar;** Contact: Dottie Dance, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 876-7535.

NOVEMBER

14-16—*Sea Island;* **Primary Care of Hand Injuries;** Contact: Amer. Soc. for Surgery of the Hand, 2600 S. Parker Rd., Ste 132, Aurora, CO 80014. PH: 303/755-4588.

16-19—*San Antonio, TX;* **Southern Medical Association's 74th Annual Scientific Assembly;** Contact: SMA, 2601 Highland Ave., Birmingham, AL 35205. PH: 205/323-4400.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.

©WEIGHT WATCHERS INTERNATIONAL, 1977

Serving the General Insurance needs of the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Tenuate® ℞
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema, *Endocrine*: impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

Merrell

9-4672 (Y957A)

Overweight may not always be simple... complications can develop.*
Complicated or not...

Tenuate® Dospan® ℂ℣
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc.
Manati, Puerto Rico 00701

JOURNAL
of the medical association of
georgia

A History of Medicine in Atlanta and Fulton County

Part II: Turn of the Century to Treachery

AVALON WOODRUFF BRYANT, *Atlanta**

It was a cold day. The temperature never reached above 26 degrees, and a few of the lakes were frozen over enough for ice skaters to whirl and tumble about in unaccustomed sport. This day was Monday, January 1, 1900, and the first time that the City of Atlanta had witnessed the beginning of a new century. Other cities in Georgia had been around to see the beginning of the 1800's, but this booming, young giant was only a little over 50 years old. On this day, Atlanta's population was 89,872, and Fulton County had a population of 117,363, representing 5.3% of the population of the State of Georgia.[1] At that turn of the century, Atlanta was an easy-going, prosperous, pleasant place to live.

The growth and changes which had taken place in Atlanta during the 19th Century were equalled or even surpassed by the rest of the nation. The speed at which the United States had grown astounded observers in the older nations. The changes were not just in size but also in kind. Thomas Jefferson's earlier America, where "everyone may have land to labor for himself, if he chooses," had disappeared. In its place by the turn of the century was a nation where fewer than four workers in 10 were in agriculture; four families in 10 lived in an urban area; industry produced 31.9% of the world's coal, 34.1% of its iron and 36.7% of its steel.[2] With a population larger than that of any European country except Russia and with exports greater than the United Kingdom's, the United States was already the foremost industrial country of the world.

The businessman had become the most important figure in this society, whereas the merchant, the factor, and the banker had been most important in earlier times. It was at this time that many of the large personal fortunes began to be amassed. No income taxes were taken from these enormous fortunes. There were no regulatory governmental agencies to interfere with their methods of doing business. They were answerable only to their own consciences. A handful of very rich private citizens wielded immense power, and this was perhaps the most striking fact about the United States at the beginning of the 20th Century.

The first "horseless carriage" made its appearance on the streets of Atlanta in this year and, in 1902, crates of these shining machines found their way into the city. Local physicians began to wonder about trading in the usual horse and buggy equipage for the exciting but cantakerous new conveyances. Not so with the ambulances, however, for they had to have the proven dependability of horses. Grady Hospital had been built in 1891 (Figure 1). It had ambulances pulled by horses, and when its gong was sounded, the people pulled over to let it pass, not knowing whether it was an ambulance or a fire wagon. Dr. Emmett W. Walton became an intern at Grady in 1907. He was the only driver on duty for 24 hours each day — except Thursday. At the turn of the century, there were two ambulances shaped like

* Mrs. Bryant is married to Milton F. Bryant, M.D., an Atlanta surgeon. She is Past President of the Auxiliary to the Medical Association of Atlanta, Past President of the Auxiliary to the Medical Association of Georgia, and currently on the Board of the Southern Medical Association Auxiliary. Her address is 3569 Dumbarton Rd., NW, Atlanta, GA 30327. This paper was presented to the Atlanta Historical Society in 1977. Part I of Mrs. Bryant's paper appeared in the April 1980 issue of the *JMAG*.

wagons, painted black with gold letters, and usually pulled by two horses. Since Dr. Walton was always on emergency call, he lived over the stable. He kept his trouser legs standing in his boots at night, and in 3 minutes he was ready to go. Like those of the fire department, his horses were trained to back into the harness and start off immediately.[3]

A History of Atlanta's Major Hospitals

The new Henry Grady Memorial Hospital with its 21½ stories has modern laboratories and facilities for training doctors and nurses, beds enough to care for 40,000 in-patients a year, and records over 750,000 yearly out-patient visits. The emergency room at Grady on Saturday night is still the scene of triumphs and tragedies and remains a turbulent place of training for many of today's doctors. "Sliding the benches at the Gradies" has speeded up considerably, however, to care for the thousands of sick and injured people who come there for help each year.

Many of the doctors of that day still wore heavy beards, black frock coats, and tall beaver hats, but this was soon to change. Not too long before, Dr. W. S. Elkin had created a sensation by cutting his long blond beard and appearing clean-shaven. The beginning of the 1900s had given the people a sense of newness, a desire for progress, and a determination to be about their business with vigor.

Part of the business of the doctors of Atlanta, it seems, was to provide places for their patients to receive care, for at this time the only sizable hospitals were St. Joseph's Infirmary and Grady Memorial Hospital, both of which were established in the late 1800s. In November of 1901, in a rented house on Courtland Street, Dr. Len G. Broughton (D.D.) opened a small infirmary. The first day of its opening brought three patients, and members of Dr. Broughton's church, the Baptist Tabernacle, scurried to supply food, furnishings, and other needed supplies. The hospital came to be known as the Tabernacle Infirmary. After a few years, the infirmary outgrew the small, rented house and moved to an old home at 69 Luckie Street, and later, in 1908, to a building next door to where the new Baptist Tabernacle was soon to be. The Tabernacle Infirmary soon grew to be too much of a responsibility for one church to maintain and in 1913, was purchased by the Georgia Baptist Convention for $85,000. It was at this point that the Tabernacle Infirmary began to operate as the Georgia Baptist Hospital. In 1921, the present site of the Georgia Baptist Hospital was acquired and business was begun at the Boulevard location. Needs continued to be met, and in 1948 a great new building program was begun which remains active today. Georgia Baptist Hospital, with its training programs for doctors and nurses, continues to meet the needs



Figure 1 — A view of Grady Memorial Hospital in 1895. The building was 4 years old. Courtesy of the Atlanta Historical Society

of people from all over the state and from other states as well.

Piedmont Hospital, originally called the Piedmont Sanitarium derived from the old Amster's Private Sanitorium and was founded in 1905 by Dr. Ludwig Amster in the former Charles T. Swift home at the northwest corner of Capitol Avenue and Crumley Street. In those days it was a small, private institution consisting of eight or 10 beds in which the patients of Dr. Floyd W. McRae, Sr., were hospitalized. In 1908, the hospital was enlarged, and adequate facilities for both medical and surgical patients were provided when Dr. McRae was joined by Drs. E. Bates Block (Figure 3), Michael Hoke, and James E. Paullin. Still using the old Swift home as a nucleus, the hospital expanded to include the entire block (Figure 2). It was well-equipped and capable of treating many kinds of illnesses. Subsequently, the hospital purchased "Deerland," the former home of Jack J. Spalding, on Peachtree Road, and a much larger, completely modern hospital was built on that site. Today Piedmont Hospital is flanked by adjacent buildings, such as its research buildings, nursing school buildings, and two large, professional office buildings. Additions to the laboratory and x-ray facilities have been completed and a larger Emergency Clinic with increased facilities, another library, and an office space unit have been joined by a new 168-bed wing. It has been said that the delivery table in the old Piedmont Hospital stood where first base is today in the Atlanta Stadium. It has not been possible, however, to completely substantiate this. A huge, old magnolia tree, which you see upon entering the Atlanta Stadium from the right field side, stood on the grounds at the old Piedmont Hospital. Perhaps a doctor who worked there in the delivery room remembers seeing this tree out the window, and this is how the story got started.

In 1908, two young Atlanta surgeons, Dr. Edward C. Davis (Figure 4) and Dr. Luther C. Fisher, were aware of Atlanta's need for hospital beds to take care of private patients. On May 2, 1937, an article



Figure 2 — The Piedmont Sanitorium grew steadily, and by 1934 expanded to include the entire block. It was well-equipped and capable of treating many patients

Courtesy of the Atlanta Historical Society



Figure 3 — Dr. E. Bates Block (c. 1920) was among the pioneer medical staff at the Piedmont Sanitorium when it was first opened at the beginning of the 20th Century.

Courtesy of the Atlanta Historical Society

appeared in the Atlanta Constitution written by Dr. Fisher which tells of the beginnings of what is now Crawford W. Long Memorial Hospital.

"It was in 1908 that the late Dr. E. C. Davis and I saw the great necessity of a private hospital as there existed in Atlanta at that time only St. Joseph's Infirmary and the Grady Hospital, and some other comparatively small private institutions. . . .

"There being a great need for hospitals for private patients, and both of us having the ambition to do surgery, for which we were especially trained, we decided in order to attain our ambition it was necessary for us to build and operate an institution of our own. Dr. Stockard had, with some associates, built a small hospital on Crew Street. In his day it was operated as a private hospital (later the Atlanta Hospital), mostly for medical cases, with a limited capacity of about 18 beds.

"In 1908, Dr. Stockard decided to discontinue the operation of his hospital, so Dr. Davis and I leased the building for a term of 2 years, with the privilege of renewal, and opened the Davis-Fisher private sanitorium [Figure 5]. An apartment house across the street was leased for the nurses' living quarters. This gave a total bed capacity for 26 patients.

"It was only a short time before the capacity of the hospital was over-taxed, and we decided to build a hospital on the north side. Accordingly, a lot was purchased in 1909 from Mrs. Morris Brandon located on Linden Street between the Peachtrees. At that time this location was considered by the medical profession and the public to be too far out for a hospital. Now it is the center of medical buildings for doctors' offices.

"During the time our plans were being considered there were several fires in hospitals over the United States. . . . These fires all occurred in wooden structures, and not one fireproof building was destroyed, nor had patients been injured. The erection of the building was begun in 1910, or the latter part of 1909. Due to the fires that were reported in the daily papers, we determined to build a fireproof building.

"Notwithstanding the fact that we were both young doctors with an unlimited ambition and a vision for the future, it was a task to assume approximately three times the estimated cost of a wooden structure without financial assistance. There were others of our associates who agreed to help us build the institution, but withdrew on account of the excessive cost of fireproof construction. In those days Captain Robert J. Lowry was president of the Lowry National Bank. We explained to Captain Lowry the necessity for a hospital where we might do our work under our own supervision, and he agreed to help us.

"While the new building was being erected we discontinued our hospital on Crew Street, and from October, 1910, until February, 1911, our nurses and all employees were without actual employment. They were patiently and anxiously awaiting the day when the new hospital would open.

"The first operation was done by myself on February 27, 1911, for a gall bladder disease. There is still a photograph in the hospital of the 167 stones that were removed from the patient. As doctors like to say, the patient made an uneventful recovery."[4]

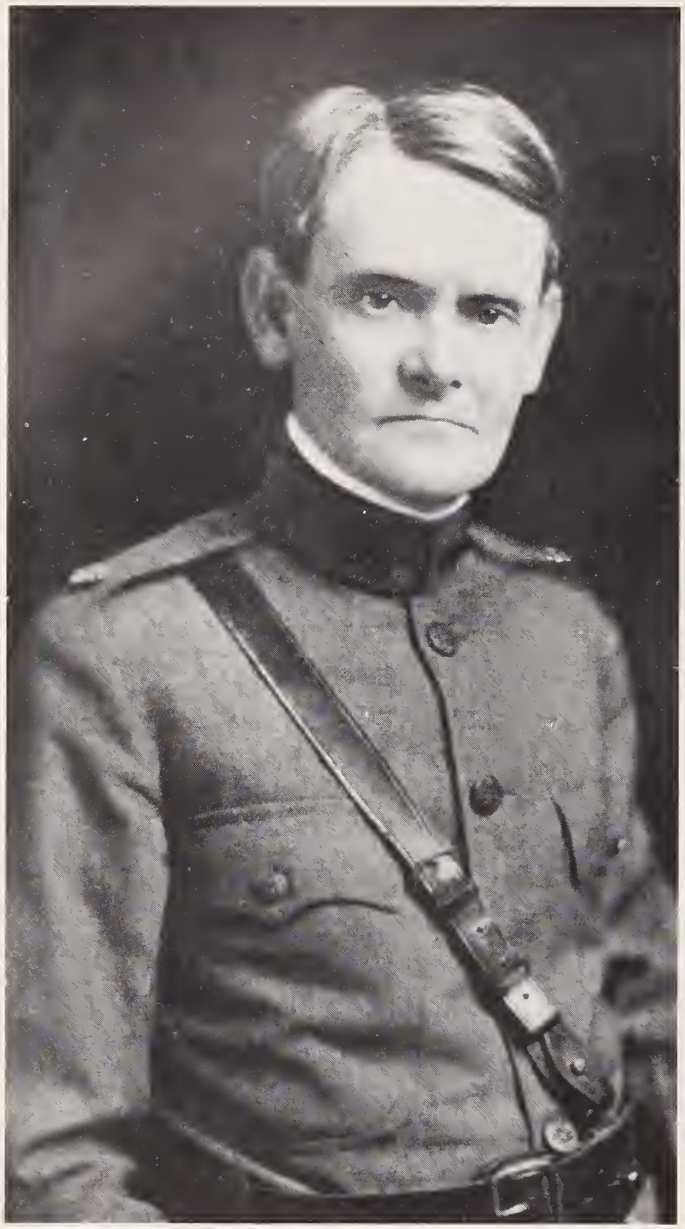


Figure 4 — At the turn of the century, physicians were integrally involved in the planning and financing of the places where patients could receive care. Dr. Edward C. Davis was one such man. It was primarily through his efforts and those of Luther C. Fisher that what is now the Crawford W. Long Memorial Hospital was built.

Courtesy of the Atlanta Historical Society



Figure 5 — The Davis-Fisher Sanitorium was one of the first fireproof hospitals built in the region.

Courtesy of the Atlanta Historical Society

During the next 10 years, the Davis-Fisher Sanitorium outgrew the original building, and so an adjoining lot was purchased in 1921. An additional fireproof building was opened to the public in May, 1922, giving the hospital a total capacity of 210 beds.

A great loss occurred to the hospital and the community when on March 12, 1931, Dr. E. C. Davis died. In the year prior to his death, it had been decided to change the name of the hospital to the Crawford W. Long Memorial Hospital. On March 30, 1931, it was dedicated to the memory of Dr. Crawford W. Long who, in 1842, in Jefferson, Georgia, performed the first surgical operation using ether as an anesthetic agent.

In 1939, Dr. L. C. Fisher deeded the hospital to Emory University. Today Crawford W. Long Memorial Hospital with its affiliate, Jesse Parker Williams Hospital, has a capacity of 520 beds. It stands large and modern, covering an entire block between the Peachtrees and bounded by Linden and Prescott Streets, a site which had in the remote past been the Alexander Luckie family cemetery and in 1908 was considered too far out from the city to be useful as a hospital.

One of Atlanta's finest hospitals of today had its modest beginnings in 1905 — the same year that the forerunner of today's Piedmont Hospital began to operate. On August 16, 1905, the Wesley Memorial Hospital, formerly known as the "Calico House" (Figure 6), the ante-bellum home of Marcus A. Bell, opened with 50 beds and a staff of 34 Atlanta doctors. By 1908, a large home next to the hospital was purchased for an addition, and a house next to Wesley Memorial Church had been rented for nurses' quarters. On October 5, 1920, construction was begun on a new Wesley Memorial Hospital facing Clifton Road and located on the campus of Emory University. This new building was the result of much



Figure 6 — The ante-bellum home of Marcus A. Bell, long known as the "Calico House," was purchased by Asa Candler in 1904, and was the initial home of the Wesley Memorial Hospital, opened in 1905. This was the forerunner of Emory University Hospital.

Courtesy of the Atlanta Historical Society

hard work and planning by Mr. Asa G. Candler and other interested, public-spirited citizens. In December, 1922, the new Wesley Memorial Hospital opened, and the 25 patients in the old "Calico House," along with the employees, were transferred by ambulance to the new building.

In 1925, the deeds and title to the Wesley Memorial Hospital were conveyed to Emory University, and it was shortly after this that the hospital became Emory University Hospital. It has often been referred to as the "Coca-Cola" hospital for, in addition to the contribution of approximately $1,250,000 by Asa G. Candler for the new Wesley Memorial Hospital, much of the subsequent growth has been made possible by other monies derived primarily from Coca-Cola sources. The humanitarian generosity of Mr. Robert W. Woodruff is well known and deeply appreciated in the community.

The building of hospitals has continued to keep pace with the growing population of Atlanta and Fulton County. In addition, numerous other hospitals have been constructed in the greater Atlanta area. The 1975 Yearbook of the Georgia Hospital Association lists 19 hospitals within the Atlanta and Fulton County area. This number increases considerably as the listing moves outside of the restricted area encompassed by this paper. Excellent hospitals are now available to all in our area, and they continue to grow and improve their facilities for diagnosis and care of the sick and injured citizens.

The history of the present Emory University Medical School is not only intriguing, but quite involved. Writing for the *Journal of the Medical Association of Georgia* in May of 1937, Dr. James L. Campbell gives us the following condensed history:

"In 1854, Dr. John G. Westmoreland organized the Atlanta Medical College which continued in successful operation until the outbreak of the war. In 1861, lectures were suspended, and the building was used as a hospital until the close of the war. The college was reorganized in 1866, with Dr. John G. Westmoreland again at its head. In 1879, the Southern Medical College was organized and ran as an active rival to the old school until 1898 when the demands for better medical education made it necessary to unite the two institutions. The new school was called the Atlanta College of Physicians and Surgeons. In 1905, the Atlanta School of Medicine was organized and immediately became a creditable rival. To meet this competition, the Atlanta College of Physicians and Surgeons erected new buildings and put in new equipment. Most important of all in the future development of the institution was the establishment in 1910 of fulltime chairs in the sciences underlying the study of clinical medicine. To these chairs were called men who, by their training and the standard of their work, raised the general tone of the college and introduced the spirit of research in medicine. Again the profession realized that consolidation was better than rivalry; so in 1913 the schools were united under the historic name, Atlanta Medical College, and soon achieved a recognized standard of merit. In 1915, further prestige and strength of organization were secured through a university connection. The Atlanta Medical College became the School of Medicine of Emory University and the graduates of the contributing colleges were accepted into the body of the Emory alumni."[5]

At the time the construction of the new buildings of the Atlanta College of Physicians and Surgeons was begun in 1906, the cornerstone of the original medical college built in 1854 was opened. "The ancient cornerstone of the old building was opened on January 16th, and was found to contain several objects. Among them were a Bible, eaten up by age, but recognizable by its clasp, and gilt edges and a few words; a medical newspaper; a bottle of alcohol; a piece of white silk ribbon; an old Roman cane and a pea whistle made of horn. The latter was still blowable, and spoke after half a century's silence."[6] Today — over 100 years later — it is interesting to speculate what those early medical school pioneers wished to convey to posterity.

The Beginnings of Georgia's Medical Societies

In 1905, a reorganization of all county and state medical societies was put into effect, so in April of that year the Fulton County Medical Society was organized. Every member with the exception of the Secretary and Treasurer had to make an annual contribution of $2.00 payable on or before January 1 of each year. By 1910, annual dues were up to $6.00 (including state dues), and these were payable in installments of $3.00 each.

World Events Impact on Atlanta

While all of this growth and expansion in medicine was taking place in Atlanta and Fulton County, events were taking place in our nation and in the world that would have a telling effect on this insulated time period.

In the year 1901, through the unpredictable interposition of an assassin's bullet, Theodore Roosevelt succeeded William McKinley as President of the United States. Also in 1901, Wilhelm Röntgen was awarded the Nobel Prize in Physics for the discovery of x-rays. This was the first year of the Nobel awards. In 1901, the Rockefeller Institute for Medical Research was established, proof of the transmission by mosquito of yellow fever was offered by a commission headed by Walter Reed, and the seriousness of a disease caused by hookworm was recognized.

The year 1903 was the beginning of successive renewals of the Triple Alliance between Germany, Austria-Hungary, and Italy. In the United States, the Wright brothers flew their first airplane, and the Ford Motor Company was established.

In Europe in 1904, the Entente Cordiale was concluded between France and Great Britian. In the United States, the National Foundation for the Study and Prevention of Tuberculosis was founded, and the Mt. Wilson Observatory was opened.

The year 1907 brought about the Franco-Russian agreement which completed the Triple Entente, and in 1908 Austria annexed Bosnia and Herzegovina. In the United States, 1908 brought the election of William Howard Taft as President and the introduction by the Ford Motor Company of the classic Model T.

A superficial review of events during this 8-year period establishes a pattern which was shortly to bring Europe to a war in which the United States was initially unwilling to participate.

Due to civil unrest and the recent war of 1912-1913, the Balkans were a seething "powder keg." The fuse was lit on June 28, 1914, when the heir to the throne of Austria-Hungary, Archduke Franz Ferdinand and his wife, Sophia, visited Sarajevo in Bosnia — a province of the then powerful empire of Austria-Hungary. A 19-year-old student named Gavrilo Princip, a Serbian nationalist (Black Hand conspirator), aimed his Browning pistol and shot the Archduke and his Duchess. Both died shortly afterward. Gavrilo Princip's shots precipitated a world war. When it ended more than 4 years later, 15 million people were dead, and 21 million had been wounded.

In July and August of 1914, war broke out in Europe. Woodrow Wilson, who had been elected President in 1912, proclaimed the neutrality of the United States in World War I.

Succeeding events, including German submarine warfare and the sinkings of the "Lusitania" and the "Arabic," were among those acts which led to further U.S. involvement. On March 12, 1917, an American merchantman, the "Algonquin," went down, followed within 3 days by three other American vessels. The Germans had committed the overt acts.

In mid-March, 1917, Atlanta was selected as southeastern headquarters of the American Red Cross. On Friday, April 6, 1917, the *Atlanta Journal* loudly proclaimed:

> "U.S. IS NOW AT WAR!
> Wilson Placed His Signature to War Declaration Today."[7]

Atlanta was in the midst of a building boom when war arrived for the United States. Shortages of materials and labor soon brought this surge to a halt, and the city and its surrounding county contributed men and material toward the war effort.

A total of 7,890 men from Atlanta and 843 from Fulton County entered the various armed services to fight for their country. Among these were the members of the Emory University Medical Unit, known as Base Hospital 43 of the American Expeditionary Forces. Both Base Hospital 43 and the 82nd (All-American) Division were products of Camp Gordon and were the only units dispatched which kept their identity throughout the war. The Emory Unit, organized by Dr. E. C. Davis, was in service in France from June of 1918 to March of 1919. The value of this unit may be realized by a telegram received from General John Pershing on December 24, 1918:

> "Please accept for yourself, the officers, nurses, and men under your command and patients under your care, my most cordial Christmas greetings, with appreciation of the spirit of loyalty and enthusiasm for which the personnel of your hospital have met their obligations, and admiration for the unflinching fortitude with which the sick and those wounded in battle have met their misfortune. I trust that the coming year will bring to all of you happiness which you so well deserve.
>
> (Signed) Pershing"[8]

On Monday, November 11, 1918, the Germans signed an armistice at 5:15 A.M., and hostilities ceased on the western front at 11:00 A.M. on that day. Atlanta's citizens were happy to be aroused from their beds in the early morning hours by the newsboys shouting about the "extra" announcing cessation of hostilities.

A formal meeting was held on April 2, 1919, just prior to demobilization of the Unit. A loving cup was presented by the men of the Emory Unit to Lieu-

tenant Colonel E. C. Davis, and a permanent organization was formed on that day.

World War I, in spite of the loss of men and the injuries sustained, actually affected Atlanta far less than had the Civil War. Antebellum to Atlantans and, indeed, to most other Southerners could only have one meaning.

The Days of Depression

When the depression hit in the early 1930s, medical society members were affected as much as the rest of the population. There was a great deal of discussion about lowering fees, but the Board of Arbiters ruled in 1932 that, "Even during this economic stress we should adhere to our code of ethics. Such lack of adherence would tend to lower the standard of our profession and be detrimental to the individual physician."[9] In this same year the Bulletin also carried an article from the dietitian at one of the hospitals asking, "What Are Hospitals Using for Money?" and stating: "A few days ago, we exchanged 30 gallons of syrup in part payment of a patient's bill. This week we are taking pure orange juice. . . . After all, legal tender is not worth any more than its purchasing power."[10]

Depression or not, in 1930 Robert Tyre Jones reached the top of his remarkable career by winning the "grand slam" of golf — the U.S. Amateur, the U.S. Open, the British Amateur, and the British Open. While Bobby Jones was gaining international fame in the world of golf, another of Atlanta's citizens, Margaret Mitchell Marsh was busy working on her book, *Gone With the Wind*. The book was published in 1936, and Margaret Mitchell was awarded the Pulitzer Prize in 1937.

In 1930, Atlanta was feeling the depression along with the entire country. Unemployment became acute, and in 1932 a mass march on the courthouse by Atlanta's unemployed protested the inadequate measures taken for relief. Due to aid from the federal government which was shortly forthcoming, partial relief was obtained, and a period of intense activity in public housing development was to follow.

The Treachery

In the year 1940, Atlanta had a population of 302,288 in the corporate limits and an estimated 359,000 in the metropolitan area. The depression of the 1930s was now submerged in the flush economy of war time, for in September, 1939, World War II had begun — again in Europe. The decade was ushered in by a 10-inch snow fall, crippling traffic, power, and communications.[11] During the late spring and early summer of 1940, the war in Europe intensified. France and the Low Countries fell to the Germans, and Italy entered the fight on the German side. Local civilian defense workers mobilized and selective service became effective in October. Work on the Atlanta Naval Air Station, on the site of the old Camp Gordon at Chamblee, was begun. In July, the City Council authorized a $4,000,000 bond issue for schools and hospitals. Roy LeCraw unseated Mayor Hartsfield in September, and Eugene Talmadge was again elected Governor of Georgia.

The year 1941 brought about the replacement of the old Chamber of Commerce — City Hall building by a modern two-story building. This year also saw the culmination of a dream of many years — the construction of a magnificent new home for the Fulton County Medical Society located at 875 West Peachtree Street. After much hard work, fund raising, and planning sessions, excavation for the new building began on June 10, 1941, with the date of dedication scheduled for December 15, 1941.

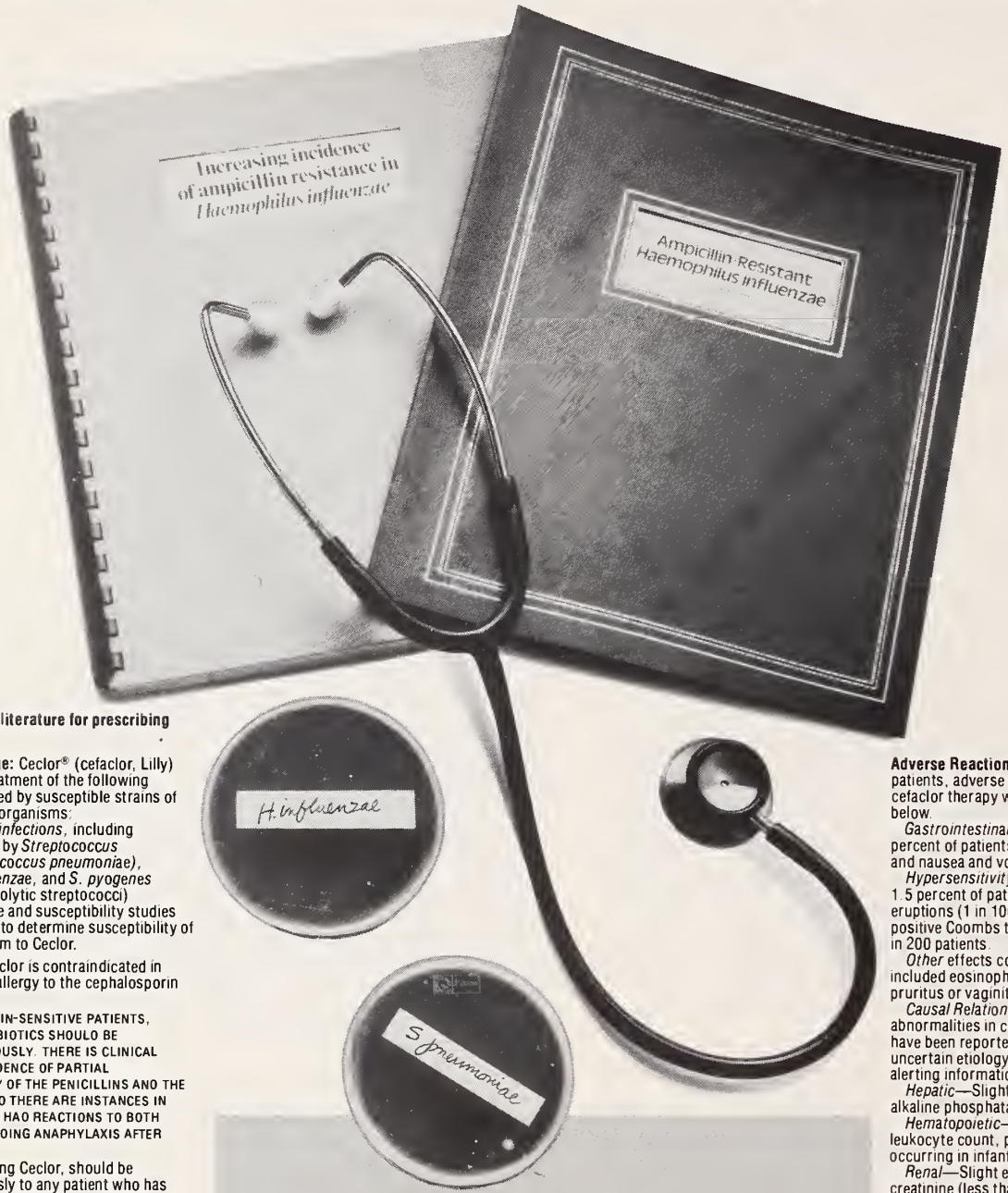
Just prior to the date of dedication for the new Academy of Medicine, a catastrophic event occurred.

On a cold, foggy morning in early December, 1941, six aircraft carriers turned south toward the Hawaiian Islands. At 6:00 A.M. on December 7, Commander Fuchida led 350 aircraft aloft toward Pearl Harbor and treachery.

References

1. Garrett FM. *Atlanta and Environs*. New York: Lewis Historical Publishing Co., Inc., 1954, 11, p. 387.
2. May ER. *History of the United States*, 1901-1917, Vol. 9. New York: Time, Inc., 1964, p. 7.
3. Garrett, II, p. 506.
4. *The Atlanta Constitution*, May 2, 1937.
5. Campbell JL. JMAG. 1937; May, p. 189.
6. Garrett, II, p. 495.
7. Ibid., p. 713.
8. Ibid., p. 743.
9. Bull Fulton County Med. 1955; 29(4):9.
10. Ibid., p. 9.
11. Garrett, II, p. 1002.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Lilly

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

000482

A review of the clinical, pathogenic, and epidemiologic features of **Campylobacter** *enteritis including a discussion of laboratory diagnostic techniques.*

Campylobacter Enteritis

CARLOS E. LOPEZ, M.D., and DEE JACKSON, M.T., A.S.C.P., *Atlanta*

Abstract

Between Aug. 10, 1979, and Nov. 10, 1979, *Campylobacter* enteritis was diagnosed in a hospital in Atlanta, Georgia, in 12 (5.2%) of all cases of diarrhea. The incidence of infection with *Campylobacter fetus* ssp *jejuni* was more common than *Salmonella* enteritis (3%), but less than *Shigella* (10%). This confirms previous experience in other parts of the country which ranks *Campylobacter* among the most common enteric bacterial pathogens in man with a potential for severe illness.

Introduction

On July 11, 1979, a 22-year-old man with a 10-day history of general malaise, abdominal cramps, watery diarrhea, fever, and weight loss was seen by a gastroenterologist. Two days later he experienced grossly bloody diarrhea. A sigmoidoscopy revealed a hyperemic, friable mucosa with a granular appearance. On follow-up 4 days later, his hemoglobin had dropped from 16 grams/DL to 10 grams/DL. A diagnosis of ulcerative colitis was suspected.

On July 26, 1979, a 16-year-old youth from Denver, Colorado, visiting in Atlanta, became ill with diarrhea and severe abdominal pain, losing approximately 10 pounds during the first week of illness. When first seen by a physician 9 days after onset of illness, he had a temperature of 102° F., with abdominal tenderness over the right lower quadrant.

On Nov. 1, 1979, a 21-year-old male student from the Georgia Institute of Technology was admitted to Piedmont Hospital with a 5-day history of diarrhea and fever. He had been treated empirically with antiperistaltic agents and ampicillin at the student infirmary and was later referred to a local gastroenterologist because he did not improve. On admission to the hospital, the patient was febrile and moderately toxic, with lower abdominal tenderness. Sigmoidoscopy showed marked mucosal friability and granularity consistent with acute ulcerative colitis.

On Nov. 26, 1979, a 31-year-old businessman had onset of shaking chills, a temperature of 103° F., explosive watery diarrhea, and severe abdominal cramps. He had about 30 watery stools per 24 hours at the peak of his illness. He was admitted to West Paces Ferry Hospital and received Lomotil and ampicillin empirically. He continued to have severe abdominal cramps, chills, and fever. Five days after onset of his illness, grossly bloody diarrhea developed. An enlarged tender liver and left lower quadrant abdominal tenderness were noted on examination. Blood cultures became positive after 2 days of incubation for a "peculiar gram-negative" organism.

The above cases represent enteritis with a unique common factor: infection with *Campylobacter fetus* ssp *jejuni*. Even more important is that this infection, with a clear potential for severe illness as illustrated by the above cases, has an antimicrobial susceptibility pattern different from other known enteric pathogens, and is *not* routinely checked for in many clinical laboratories.

Background

Campylobacter ("curved bacterium") *fetus* was formerly known as *Vibrio fetus*, but it was reclassified under the genus *Campylobacter* in 1963, since it has biochemical, antigenic, and nucleic acid characteristics which differ from *Vibrios* (e.g., *V. cholerae, V. parahemolyticus*). It is a slender,

* Dr. Lopez is an internist and infectious disease specialist. Miss Jackson is Chief, Microbiology Laboratory, Piedmont Hospital, Atlanta. Send reprint requests to Dr. Lopez at Colony Medical Group, 400 Colony Square, Ste. 1605, Atlanta, GA 30361.

curved, gram-negative rod, assuming a comma or S-shape in most cases, with occasional filamentous forms resembling spirochetes. *C. fetus*, the only one of its species recognized as a human pathogen, is further divided into two subspecies (ssp): *intestinalis* and *jejuni*. *Campylobacter* infection was formerly thought to occur rarely, and prior to 1970, the only recognized cases were in severe extraintestinal infections (septicemia, endocarditis, pericarditis, meningitis, thrombophlebitis, septic arthritis, and abscesses) usually occurring in a debilitated host. Most of these (approximately 90%) were identified as ssp *intestinalis* infections. Since the first report from Brussels of the successful recovery of *C. fetus* ssp *jejuni* from human stools in 1972, it now appears that it is among the most important enteric bacterial pathogens in man.

Epidemiology

The majority of acute diarrheal syndromes in man run a short, self-limited course. Viruses (reo and parvo viruses) probably account for the majority of these episodes, and a specific diagnosis is not generally necessary except for epidemiologic investigations. Among bacterial agents of diarrhea, it was until recently felt that only *Salmonella* and *Shigella* justified their routine culture in stools, given their relatively higher incidence and potential severity. It is clear that *Campylobacter* has gone unrecognized for some time by many clinical laboratories due to the lack of familiarity with this fastidious slow-grower which, contrary to most other known enteric pathogens, requires incubation under low oxygen tension and highly selective culture media.

In a 3-month period from Aug. 10 to Nov. 10, 1979, stool specimens from 230 patients were submitted to the microbiology laboratory at Piedmont Hospital in Atlanta and were routinely cultured for *Salmonella, Shigella,* and *Campylobacter*. *C. fetus* ssp *jejuni* was recovered from 12 (5.2%) of the specimens. This was second only to *Shigella* which occurred in 23 (10%) of patients and more frequently than *Salmonella,* which was isolated from 7 (3%) of this population. This incidence of *Campylobacter* diagnoses is remarkably similar to that reported previously in the United States.[1, 2]

C. fetus has been recognized by veterinarians for many years as a cause of enteritis, infectious abortion, and hepatitis in ungulates, including cattle and sheep, and in fowl. It can also occur commensally in these animals, as well as in swine, dogs, cats, and rodents. *Campylobacter* may occur as a commensal in dogs, but it may also cause diarrhea in them.

The transmission of *Campylobacter* infection in man most likely occurs through the oral route. Water, unpasteurized milk, food including garden vegetables, humans, and animals (e.g. poultry, dogs, cattle) may serve as sources of infection. In the cases presented here, there was history of exposure to poultry in Case #1 who visited a chicken farm frequently, and also in Case #2 who had a job in a fried chicken franchise involving the handling of raw meat. Case #4 owned an apparently healthy dog. There was no history of unusual exposures in Case #3.

Since the first report of its successful recovery from human stools in 1972,* C. fetus *ssp* jejuni *has become recognized as one of the most important enteric pathogens in man.

Pathogenesis

The pathologic hallmark of infection with *Campylobacter* is that of inflammatory bowel disease. In a few fatal infections, necropsy has been characterized by hemorrhagic necrosis of the jejunum and ileum. In one patient undergoing emergency laparotomy for suspected bowel perforation, a markedly edematous ileum was observed with free intra-abdominal fluid, suggestive of peritoneal irritation. Patients undergoing sigmoidoscopy show inflammation and friability of the colon, and biopsy will generally reveal crypt abscesses and infiltration of the lamina propria with neutrophils, plasma cells, and lymphocytes. These pathologic changes appear to be due at least in part to the ability of *Campylobacter* to invade the bowel lumen, as evidenced on electronmicroscopy which has revealed vibrio-like strùctures within the bowel mucosa. These gross and histologic changes appear to be reversed by specific antimicrobial therapy (e.g., erythromycin).[3]

Clinical Manifestations

It is possible that many cases of enteric *Campylobacter* infection develop a nonspecific, self-limited gastrointestinal illness that never comes to the attention of the physician. At least one fourth of untreated cases will recur, though usually in a milder form than the initial illness. The illness can be prolonged, and one lasting several months has been reported.[4] The majority of patients with culture-proven infection, however, have presented with the abrupt onset of cramping abdominal pain, which may be very severe. At times, it has been mistaken for a perforated viscus. Within 24 hours after onset of abdominal pain, diarrhea develops which may, in about 40% of the cases, evolve into a grossly bloody diarrhea or melena. Significant blood loss can occur as illustrated by Case 1 above. Fever develops in the great majority of patients during the first few days of illness, and constitutional symptoms are frequent. The illness usually lasts about 7 days.

Laboratory Diagnostic Techniques

On laboratory evaluation, about two thirds of the cases present with peripheral leukocytosis. Wet mounts of stools, or preferably stool mucus, in buffered methylene blue will reveal the presence of many polymorphonuclear leukocytes in about 80% of the cases. This and the presence of gross or microscopic blood in the stools (60%) categorize *Campylobacter* enteritis among the invasive enteric bacteriae which include *Shigella, Salmonella, Yersinia enterocolitica, V. parahemolyticus,* and invasive *Escherichia coli*. In most infected patients, a significant rise in specific antibodies will develop to the *C. fetus* ssp *jejuni* isolated from their stools.

Selective culture methods are necessary for the isolation of *C. fetus* ssp *jejuni* from stool specimens. Techniques routinely used for the isolation of *Salmonella* and *Shigella* are not adequate. Its relatively slow growth requires the addition of antibiotics to the media to prevent being overgrown by the normal enteric flora. In addition, microaerophilic incubation at 37° C. or preferably 42° C. is necessary, and an atmosphere of 5% oxygen, 10% carbon dioxide, and 85% nitrogen is considered optimal. Laboratories lacking facilities for gasing-out incubation jars could use the familiar anaerobic jar with a hydrogen-carbon dioxide generator (Gas-Pak). Since *Campylobacter* does not grow well under strict anaerobic conditions, the catalyst should be removed from these jars. In most cases, growth is evident by the first 24 hours of incubation; however, plates should also be examined at 48 and 72 hours before discarding. ***A note of caution:*** in view of the high hydrogen content of the atmosphere generated by the Gas-Pak technique, the jars should be opened away from open flames.

Campylobacter ***organisms have a different antimicrobial susceptibility pattern and are not routinely checked for in many clinical laboratories.***

Among the selective media used for the isolation of *Campylobacter* species, *Skirrow's* medium (the one used in this work) is probably the one most often used, and it is available locally (e.g., Carr-Scarborough Microbiologicals, Inc., Decatur, Georgia; Nolan Biological Laboratories, Tucker, Georgia). It is a horse-blood agar medium with added polymyxin B, trimethoprim, and vancomycin. While this medium permits the stool isolation of not only *C. fetus* ssp *jejuni* but also the exceedingly rare *C. fetus* ssp *intestinalis,* overgrowth with the normal enteric flora and yeasts sometimes becomes a problem. For this reason, more selective media have been recommended, specifically for the recovery of the commoner *C. fetus* ssp *jejuni* from stools. These include *Campy-BAP,* which is a 10% sheep blood-brucella agar medium with added amphotericin-B, cephalothin, trimethoprim, and vancomycin, and *Butzler's,* which is a sheep blood-thioglycollate-agar medium with added antimicrobials (actidione, bacitracin, cephalothin, colistin, and novobiocin). Neither *Campy-BAP* or *Butzler's* media are commercially available at this time. The two local laboratory suppliers mentioned above plan to make *Butzler's* medium available in the near future.

The highest rates of recovery of *C. fetus* ssp *jejuni* from stools are achieved when direct plate inoculation is supplemented by cold enrichment of the stool specimen in a liquid medium (Campy-Thio) consisting of thioglycollate broth with 0.16% agar plus the antimicrobials present in the Campy-BAP medium described above.

Other details on the isolation and characterization of *Campylobacter* species are given elsewhere[4, 5, 6] or can be obtained from Dr. Robert E. Weaver, Chief, Special Bacteriology Section, Bureau of Laboratories, Center for Disease Control, Atlanta, Georgia 30333.

Treatment

As mentioned previously, many cases of enteric campylobacteriosis probably run a mild, self-limited course. However, prolonged and debilitating disease can occur, and about one-fourth of untreated cases will experience a recurrence of symptoms. In view of this, and since person-to-person spread can occur, severe disease can develop unpredictably, and because safe, effective therapy is available, the authors feel that all symptomatic cases of *Campylobacter* enteritis should be treated, barring any contraindications.

Erythromycin appears to be the drug of choice for the treatment of uncomplicated *Campylobacter* enteritis. A 7-day course of 50 mg/kg/day has been used successfully[1], but in our experience lower doses (approximately 30 mg/kg/day) are equally effective and better tolerated. Alternatively, oral furazolidone or tetracycline may be used, based on favorable in vitro data which show that approximately 100% and 90% of strains of *C. fetus* ssp *jejuni* are susceptible to these two drugs respectively.[4] Chloramphenicol is also highly active in vitro, but its oral administration is discouraged, since there are other equally effective and safer drugs. In the treatment of septicemia, parenteral gentamycin or chloramphenicol are recommended, although erythromycin has also been effective. Only 60% of strains of *C. fetus* ssp *jejuni* are sensitive to ampicillin. Neither cephalothin nor penicillin-G display significant activity against this bacterium.

The use of antiperistaltic agents (e.g. diphenoxylate-atropine = *Lomotil;* loperamide = *Imodium;* opiates) in *Campylobacter* enteritis, as in other enteritises producing inflammatory bowel disease, is discouraged. The potential for aggravation of the disease process itself has been emphasized previously in the course of induced *Shigella* infection[7]. The theoretical possibility of development of toxic megacolon also exists. Less potent anti-diarrheal agents such as kaolin-pectin compounds or bismuth-subsalycilate (PeptoBismol) are probably safe. However, it must be remembered that the latter compounds will render stools unsatisfactory for parasitologic examination.

All four cases presented here received 2 grams of erythromycin daily for at least 7 days, and there have been no recurrences. Case #4, who had a bacteremic infection, received treatment for a total of 10 days and continued to do well 2 months later, with negative stool and blood cultures. In Cases #1 and #3, results of repeat sigmoidoscopy were normal after a 7-day course of erythromycin therapy.

Acknowledgements

We thank Drs. T. Sterling Claiborne, Thomas S. Claiborne, Jr., Joseph H. Hilsman, and William H. Whaley from Atlanta, Georgia, for providing us with their patients' clinical histories and allowing their publication.

References

1. Blaser MJ, et al. *Campylobacter* enteritis: clinical and epidemiologic features. Ann Intern Med 1979; 91:179-185.
2. Shaefer JR, et al. *Campylobacter* enteritis — Iowa. Morbid Mortal Weekly Rep. 1979; 28:565.
3. Blaser MJ, et al. Acute colitis due to *Campylobacter fetus* ssp *jejuni* in Proceedings of 19th Interscience Conference Antimicrobial Agents and Chemotherapy, October 1979, Abstract No. 182.
4. Butzler JP: Infection with *Campylobacters,* in: Williams JD (Ed): *Modern Topics in Infection.* London: William Heinemann Medical Books Limited. 1978; p. 214-239.
5. Reller LB, et al. *Campylobacter* enteritis: *Campylobacter fetus* subspecies *jejuni.* Critique on Microbiology Check Sample No. MB-99. Chicago, Illinois. American Society of Clinical Pathologists, 1979.
6. Phillip DA, et al. *Campylobacter* and *Spirillum,* in: Seligson D (Ed): *CRC Handbook Series in Clinical Laboratory Science,* Section E: Clinical Microbiology (Volume I) Cleveland, Ohio: CRC Press, Inc. 1977; p. 279-289.
7. Dupont HL, et al. Adverse effect of Lomotil therapy in shigellosis. JAMA 1973; 226:1525-1528.



"Appropriateness Review can be an effective tool to help maximize benefits and minimize costs in the health care field."

Appropriateness Review: The Georgia Experience

JACK BERNARD, Atlanta*

Introduction

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) created both the State Health Planning and Development Agencies (SHPDAs) and the Health Systems Agencies (HSAs). There are seven HSAs in Georgia in addition to the Georgia SHPDA, which is located in Atlanta. The primary function of these health planning agencies is to determine current and future health service needs in the state through the utilization of health plans.† The agencies then make sure those needs are met by conducting "project reviews" (e.g., Certificate of Need, or Section 1122) of proposed new institutional health services and encouraging the development of necessary health care resources.

Federal law also requires that these agencies conduct "Appropriateness Reviews" to find out how well health service needs are being met by existing health care institutions. This process bridges the gap between planning and regulation. Health plans, which include standards and goals for improving health care services, are the basis for regulatory decisions, and Appropriateness Review provides information to better develop these plans. Public and private hospitals, rehabilitation facilities, home health agencies, and nursing homes are subject to this kind of review. In our state, physicians' offices will not be subject to Appropriateness Review, although data will be gathered from them.

How do these reviews differ from other "project reviews?" To begin with, the planning agencies (SHPDA and HSAs) *initiate* Appropriateness Review, and the process involves reviewing a "service" (described later in this paper), as it is offered at all health care institutions within a particular service area or the entire state. In addition, Appropriateness Review is concerned primarily with *existing* institutional health services, whereas Certificate of Need reviews are concerned with proposals of *new* institutional health services.[1] Finally, Appropriateness Review involves only those specified services which have expenditures in excess of $75,000 annually.[2]

The History of Appropriateness Review in Georgia

Georgia's SHPDA has had numerous reservations about initiating statewide Appropriateness Review. These reservations derived partly from the lack of clarity in the federal legislation as to the purpose and expectations of the reviews; from the lack of timely regulations and other guidance from the Department of Health and Human Services (DHHS) (formerly DHEW); and from the excessive burdens that would be placed on health planning agencies in relation to their resources. Nevertheless, SHPDA began preparing for these reviews in December, 1978, when representatives from SHPDA and the HSAs attended a series of meetings to discuss Appropriateness Review.[3] A draft position paper on Appropriateness Review was then developed as a result of these meetings.

Georgia's SHPDA decided to delay development of a draft plan explaining how Appropriateness Review would be conducted until after the DHHS issued final rules on how this should be done. The Federal Register of Dec. 11, 1979, contained these final rules, and SHPDA subsequently constructed a draft plan with input from all HSAs. This document, called the *Georgia Appropriateness Review Work Program and Plan,* was distributed for public com-

* Mr. Bernard is Chief of Planning, Georgia SHPDA. Address reprint requests to him at 43-A, Executive Park East, NE, Atlanta, GA 30329.

† When a review is being conducted, health plans previously developed are used as a "measuring stick" to see how well health care needs have been met since the plans were originally drawn up.

ment, and a public hearing was held March 14, 1980.

Comments were received from the Medical Association of Georgia, the Georgia Hospital Association; the Health Systems Agency of Central Georgia; the Georgia Department of Human Resources' Division of Vocational Rehabilitation, Office of Regulatory Services, and Division of Mental Health and Mental Retardation. Several adjustments were made to the proposed plan after receiving these comments. The adjustments concerned the clarification of service definitions (yet to follow), data requirements in nonhospital settings, and were included in the final document sent to DHHS on April 1, 1980.[4] Subsequently, in June 1980, Georgia's HSAs initiated some Appropriateness Reviews throughout the state. SHPDA will initiate its Appropriateness Reviews in December 1980.

As already indicated, Georgia's SHPDA has overall responsibility for data collection and dissemination, review coordination, and all final findings.

SHPDA has also developed a draft of a comprehensive review manual for Appropriateness Review. This manual has recently been distributed for public comment and contains the state level procedures to be followed in Appropriateness Review, definitions of specific services to be reviewed, criteria and standards that will be utilized, hearings and appeal procedures, and the format of Agency findings.[5]

Appropriateness Review: State Level Implementation in Georgia

As mentioned, then, Georgia's SHPDA and HSAs will conduct Appropriateness Reviews for those services designated as priority areas in national guidelines issued by the DHHS.[6] This includes general hospital bed capacity and utilization, obstetric services, neonatal services, pediatric services, and specialized services such as open heart surgery, cardiac catheterization, radiation therapy, computerized tomographic (CT) scanning services, and end-stage renal disease services (ESRD). Short and long-stay mental health in-patient services, both free-standing services and services in general hospitals, will also be addressed. Long-term care services reviewed will include nursing homes and home health care. In addition, Appropriateness Review will encompass emergency medical services (EMS) which are addressed in Georgia's Preliminary State Health Plan.

Definitions for all these services are contained in the *Appropriateness Review Work Program and Plan,* which is available from SHPDA.[7] The HSAs use definitions, priorities, and schedules consistent with those in SHPDA work program and plan.

The Appropriateness Review process is scheduled in five phases as follows:

(1) General hospital beds;

(2) Obstetric-Pediatric-Neonatal beds;

(3) Cardiac catheterization, open heart surgery, and CT scanners;

(4) Radiation therapy, ESRD, and EMS; and

(5) Mental hospitals, nursing homes, and home health care agencies.

SHPDA and the HSAs will conduct *sequential* reviews. For each phase, all HSAs will begin by evaluating each service in their areas as listed. Each HSA must notify every affected institution in writing that the Appropriateness Review process for a specific service is beginning. The HSAs have 180 days after a review starts to submit their written findings to SHPDA. The HSAs must provide a public hearing in the course of a review if so requested by those whom the review directly affects.

After receiving the HSAs written findings of the review, SHPDA then begins its review of that particular service after again providing written notification to all affected institutions. Similarly, SHPDA will complete its review within 180 days and must also hold a public hearing if requested by the parties involved.

Generally, the service review areas will coincide with HSA boundaries. However, since service areas are not identical for all services, adjustments may result as Appropriateness Review progresses. In making these adjustments, the planning agencies will solicit input from providers of health services.

SHPDA does not intend to publish findings which solely address the appropriateness of a service provided at a specific health care institution. Remedial action plans, however, which suggest ways a service could be altered to better meet the population's health needs, may refer to specific institutional changes which should be accomplished in the service area. In addition, SHPDA may elect to issue institution-specific findings in the future.

As stated earlier, no findings will address physicians' offices, although the planning agencies may collect data from physicians' offices in order to accurately assess utilization and accessibility of institutional services. This is an area in which the Medical Association of Georgia can greatly aid both the HSAs and SHPDA.

Inappropriateness — How It Is Determined

To support a finding of inappropriateness, the HSA or SHPDA must specify the exact ways in which the service under review deviates from the adopted criteria. These criteria involve availability, accessibility, cost, continuity, acceptability, and quality. On the state level, they are consistent with

the Preliminary State Health Plan for Georgia, a document developed by SHPDA and one that MAG has commented on extensively.

Of course, it is highly desirable that similar criteria and standards be used by the HSAs and SHPDA for purposes of equity. Therefore, the state will attempt to achieve this aim, although it does not have the authority to mandate this consistency. Further, although SHPDA will thoroughly consider all recommendations submitted by the HSAs involved in Appropriateness Review, the state findings must be based solely upon its own adopted standards and criteria.

Based on findings of inappropriateness, remedial action plans must be developed by the health planning agencies. These action plans will only consist of voluntary actions which might be taken by institutions offering services found to be inappropriate. Appropriateness Review includes no formal sanctions.[8]

Sources of Data

Most information used for Appropriateness Review will be taken from questionnaires already submitted by health care institutions, such as the Joint Hospital Data Questionnaire, the Joint Georgia Nursing Home Questionnaire, the Georgia Specialized Services Survey, and the Georgia Patient Origin Study. All HSAs will be strongly encouraged to use these data and to clear any other sources of data gathering through SHPDA; however, SHPDA cannot require totally centralized data gathering. If there are additional data requirements, the above-mentioned surveys may be modified and expanded, using recommendations from health care providers and HSAs. Only data which are auditable and verifiable will be used. As already indicated, Georgia's SHPDA has overall responsibility for data collection and dissemination, review coordination, and all final findings.[9]

The Joint Task Force for Standards and Criteria will work with the health care providers to refine standards and criteria. This coordinating group is composed of SHPDA and HSA staff members. SHPDA's coordinator for the Statewide Health Coordinating Council (SHCC) will chair the Task Force. This SHCC Coordinator is the primary source of staff assistance for the Council and will provide periodic reports about Appropriateness Review to the SHCC Review and Planning Committees, whose membership includes health care providers.

Conclusion

The SHPDA staff believes that Appropriateness Review can work in Georgia. It can be a very effective tool to help maximize benefits and minimize costs in the health care field. The potential to improve the health care delivery system through voluntary means is real. However, the program can only succeed through the continuing cooperation of health planning agencies and health service providers, especially physicians and health institution administrators.

References

1. *Health Systems Agency and State Health Planning and Development Agency Reviews — Certificate of Need Programs.* Federal Register. Washington, D.C.: DHEW, March 1980: pgs 20032, 20039-20041.
2. Health Systems Agency and State Agency Reviews of the Appropriateness of Existing Institutional Health Services Final Regulations. Federal Register. Washington, D.C.: DHEW, December 1979: pgs 71769-71773.
3. Forrest J. Initiating the Appropriateness Review Function. Atlanta, GA. Region IV DHEW. December 6, 1978: pgs 1 and 2.
4. Work Program and Plan for Appropriateness Review. Atlanta, GA. State Health Planning and Development Agency 1980: pgs 1-8.
5. Draft Georgia SHPDA Appropriateness Review Manual. Atlanta, GA. June 1980.
6. The National Guidelines for Health Planning. Health Resources Administration (Publication 79-645); Washington, D.C.; DHEW, March 28, 1978: pgs 5-11.
7. Work Program and Plan for Appropriateness Review. Atlanta, GA. State Health Planning and Development Agency 1980: pgs 1-8.
8. Review of Appropriateness, Analysis of Final Rules. Institute for Health Planning. Madison, WI: IHP, Dec. 1979: pgs 16 and 17.
9. Rorrie C. Program Policy Notice 80-09. Washington, D.C.: DHEW, Jan. 1980: pgs 3 and 4.

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

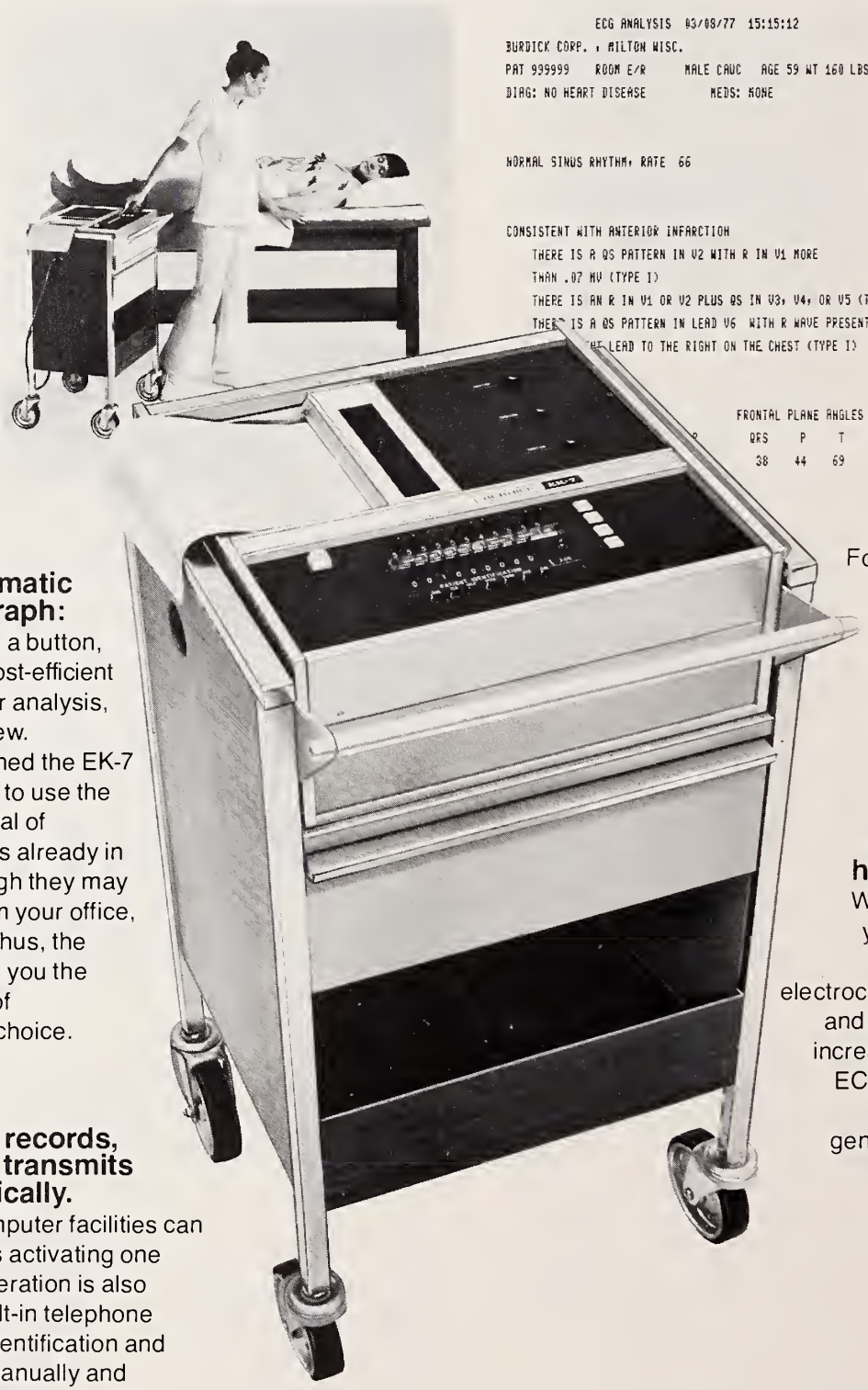
Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service

Burdick's new EK-7:

Today's intelligent answer for computerized ECGs.



Burdick's new 3-channel automatic electrocardiograph:

At the touch of a button, the EK-7 provides cost-efficient ECGs for computer analysis, ready for your review.

Burdick designed the EK-7 acquisition system to use the interpretive potential of computer programs already in service, even though they may be many miles from your office, clinic or hospital. Thus, the Burdick EK-7 gives you the greatest freedom of computer-service choice.

Burdick's EK-7 records, translates, and transmits ECGs automatically.

Access to computer facilities can be as automatic as activating one button. Manual operation is also possible with a built-in telephone handset. Patient identification and statistics are set manually and transmitted automatically.

For immediate examination you get scratch-resistant smudge-free tracings produced on Burdick's easy-to-read BlueTrace 3-channel paper.

Burdick and computer-assisted electrocardiography help meet your needs.

When you invest in an EK-7 you invest in your practice. Computer-assisted electrocardiography substantiates and augments your diagnosis, increases speed and volume of ECGs administered. For your review, you get computer-generated ECG interpretation in minutes.

Electric Research Corporation

1399 DUTCH VALLEY PLACE, N.E. • TELEPHONE 873-1084
ATLANTA, GEORGIA 30324

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.



Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episcdica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8—5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10—20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) or TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	189

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (15 ml) times a day 20-30 minutes before meals. This drug is not for use children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-0015-

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001 5-80 Printed in U.S.

NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

First Class Permit No. 1563, Shreveport, LA.

Postage will be paid by addressee

BOOTS PHARMACEUTICALS, INC.

Department 0
6540 Line Avenue
Shreveport, LA. 71106

BOOTS PHARMACEUTICALS, INC.

Shreveport, Louisiana 71106

Pioneers in medicine for the fam

A Cavitary Lesion in the Lower Lung

RICHARD B. STEWART, M.D., and ROY M. WALLER, III, M.D., *Atlanta**

Dr. Richard B. Stewart: This patient is a 31-year-old man who presented with a 4-year history of recurrent pulmonary infections accompanied by fever, a cough productive of mucopurulent sputum, and two separate episodes of hemoptysis. The patient had no history of weight loss, exposure to tuberculosis, or other medical problems. Cultures of sputum specimens and cytology were negative, as were tuberculous and fungal skin tests. Barium contrast studies of the upper and lower gastrointestinal (GI) tracts were normal. Dr. Waller, would you discuss the case please?

Dr. Roy M. Waller, III: This PA view of the chest (Figure 1) demonstrates an air/fluid level within a fairly well circumscribed, wedge-shaped soft tissue density in the posteroinferior aspect of the left lung. A lateral view shows the mass density in close juxtaposition to the posterior left hemidiaphragm, and it is sharply demarked from the normally aerated left lower lung. There is blunting of the left costophrenic angle, suggesting an associated pleural effusion without evidence of significant pleural thickening. The right lung field is well expanded and free of infiltrate, and the cardiomediastinal silhouette is within normal limits.

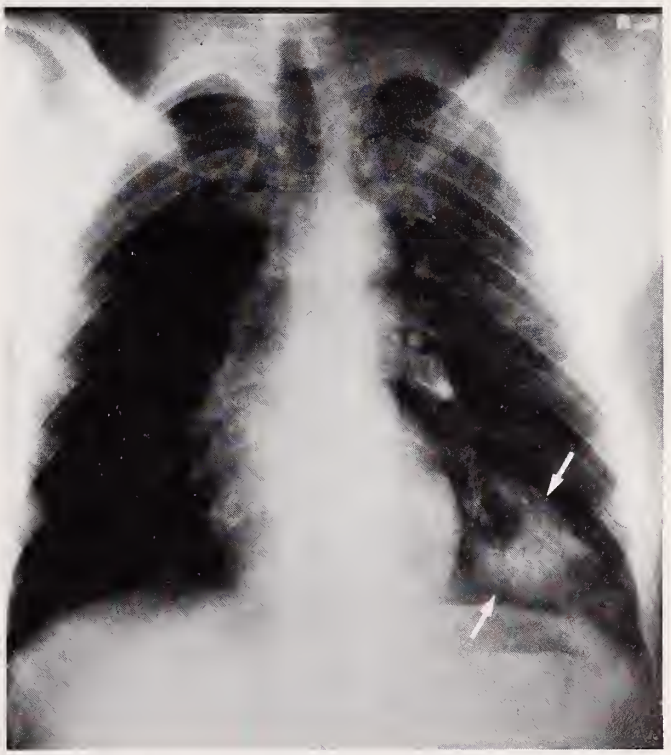


Figure 1 — PA view of the chest, demonstrating an air/fluid level within a circumscribed wedge-shaped soft tissue density (arrows) representing bronchopulmonary intralobar sequestration with superimposed infection.

This clinical and roentgenographic picture gives rise to a rather broad differential diagnosis. First, the normal upper GI and barium enema (BE) studies preclude the herniation of abdominal contents, as in a pleuroperitoneal or Bockdalek hiatal hernia, to account for the cystic mass-like infiltrate. The patient's young age, the protracted and periodic course of his pulmonary symptoms, and the absence of weight loss are features which militate against the diagnosis of a neoplasm with cavitation. The clinical presentation as well as the radiographic configuration are highly atypical for vascular lesions, such as an arteriovenous malformation or a cavitary infarct. Similarly, the negative skin test and sputum cultures argue against a tuberculous or fungal etiology. Other inflammatory pulmonary processes, including suppurative lung abscess or infected acquired pulmonary cysts, could present similarly. The absence of pertinent history and little or no pleural parenchymal fibrotic reaction militate against the more severe, chronic pulmonary lesions of cystic bronchiectasis with secondary pneumonia or an encapsulated

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, GA 30303. Drs. Stewart and Waller are from the Department of Radiology, Emory University School of Medicine, Atlanta, GA 30303. The conference material has been edited by Drs. J. L. Clements and H. S. Weems.

empyema with development of a bronchopleural fistula. The congenital pulmonary malformations of bronchogenic cysts or bronchopulmonary intralobar sequestration, with superimposed infection, would present indistinguishably from this case. Additional radiographic studies, including bronchography and arteriography, would significantly narrow the range of diagnostic possibilities.

Dr. Richard B. Stewart: A bronchogram was performed which demonstrated contrast filled peripheral, basal bronchi festooned around the left lower lobe mass, without evidence of communication. Next an aortogram was done.

Dr. Roy M. Waller, III: This film (Figure 2) from the aortogram exhibits an opacified anomalous artery of greater caliber than the splenic artery, arising from the subdiaphragmatic aorta, coursing laterally and cephalad to penetrate the left hemidiaphragm and arborize in the region of the left lower lobe mass density. A delayed film from a selective injection of this anomalous artery (Figure 3) outlines the venous drainage of the mass lesion via the pulmonary venous system.

Given the beautiful delineation of these definitive roentgenographic procedures, I conclude that the left lower lobe triangular shaped cystic density in this case represents a bronchopulmonary sequestration, intralobar type, with concomitant infection.



Figure 2 — Aortogram demonstrating an anomalous artery (arrows) arising from the subdiaphragmatic aorta and penetrating the left hemidiaphragm to supply the bronchopulmonary sequestration.

Dr. Richard B. Stewart: This patient underwent thoracotomy for removal of the left lower lobe. At surgery, the previously delineated single, large anomalous artery arising from the subdiaphragmatic aorta penetrated the diaphragm through the pulmonary ligament reflection and disappeared into the inferolateral aspect of the parenchyma. The medial basal segment of the left lower lobe contained a cystic-bronchiectatic, heterogenic mass of a reddish-gray color, clearly demarcated from normal lung parenchyma. There were scattered foci of dense, fibrous adhesions from the mass to the diaphragm and thoracic wall. Histologically, the cystic spaces were lined by ciliated columnar epithelia and filled with mucus and pus.

Comment

Dr. Roy M. Waller, III: Bronchopulmonary sequestration is a congenital anomaly which is an unusual cause of localized, non-resolving pneumonia. Originally described in 1861, it remains a much disputed entity, particularly in embryologic pathogenesis. The sequestration represents a nonfunctioning mass of lung tissue developing anatomically separate from the normal tracheobronchial tree and deriving its vascular supply from an anomalous systemic artery. Bronchopulmonary sequestrations are of intralobar and extralobar types. The intralobar anomaly, approximately four times more common, is a cystic mass of pulmonary tissue lying contiguous with the normal lung parenchyma and sharing the pleural envelope of the affected lobe. In two-thirds of reported cases, the sequestrum is located in the posterior segment of the left lower lobe. Most often the vascular supply is via the descending thoracic aorta, and the venous drainage is usually by the pulmonary veins. Communication with the normal tracheobronchial tree may be present. Intralobar sequestrations usually present clinically in adults as acute pneumonia. Hemoptysis is an infrequent presentation. The radiographic appearance depends on the presence or absence of infection. When infection has resulted in airway communication, the picture is an air-containing, cystic mass density in a lower lobe. In the absence of bronchial communication, the sequestration presents as a well circumscribed, often oval or triangular shaped, homogeneous soft tissue density, most commonly in the paravertebral gutter on the left. The extralobar sequestration represents an ectopic focus of lung tissue with its own pleural investment, and possibly as a result of this, only rarely becomes infected. The main vascular supply is again, by the thoracic aorta, but its venous drainage is usually via systemic venous channels. In

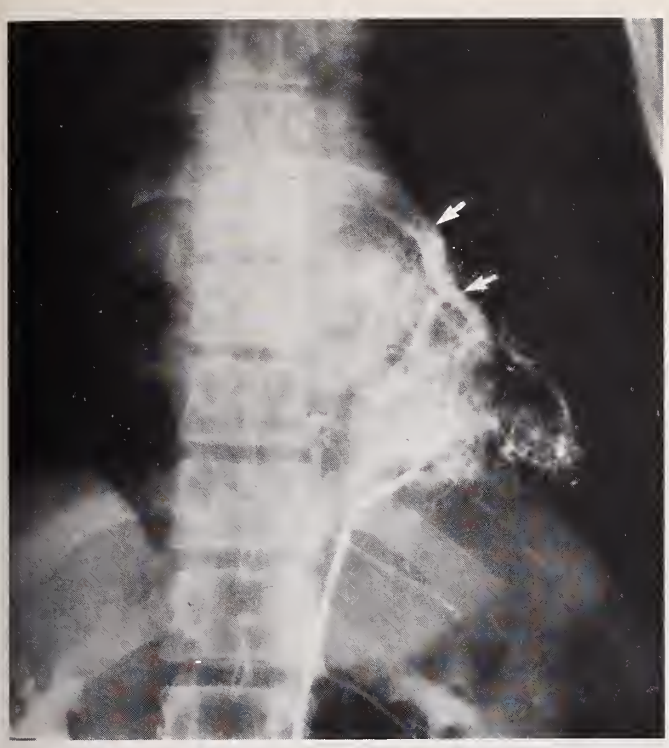


Figure 3 — A delayed film from a selective injection of the anomalous artery supplying the bronchopulmonary sequestration demonstrating the venous drainage (arrows) to be by way of the pulmonary venous system.

infants and children this left to right shunt may be hemodynamically significant, presenting with congestive heart failure. The main roentgenographic presentation is a homogeneous soft tissue mass, and in 90% of the cases juxtaposed to the left hemidiaphragm. In contrast to the intralobar anomaly, the extralobar sequestration is usually seen in children under age 2, with 50% of patients diagnosed before 6 months of age. Associated congenital malformations, such as eventration of the ipsilateral hemidiaphragm and congenital diaphragmatic hernia, have been described in the extralobar type.

Therapy for symptomatic bronchopulmonary sequestration is surgical resection of a pulmonary segment or lobe. Considering the danger of accidental section of the anomalous systemic vessels, preoperative aortography is crucial to delineate the site and the number of aberrant vessels.

References

1. Durnin RE, Lababidi Z, Butler C, et al. Bronchopulmonary sequestration. Chest 1970; 57:454-459.
2. Sade RM, Clouse M, Ellis FH Jr. The spectrum of pulmonary sequestration. Ann Thor Surg 1974; 18:644-655.
3. Flye MW, Conley M, Silver D. Spectrum of pulmonary sequestration. Ann Thor Surg 1976; 22:478-482.
4. Fraser RG, Pare JAR. *Diagnosis of Disease of the Chest*. Philadelphia: W.B. Saunders, 1974, 2nd ed, pp 606-612.
5. Savie B, et al. Lung sequestration. Thorax 1979; 34:96-101.
6. Sagel SS. *Special Procedures in Chest Radiology*. Philadelphia: W.B. Saunders, 1976, p 124.

Introducing...

TEGA-CORT FORTÉ 1% - TEGA - CORT - 0.5%

(Available at all drug stores - Rx Only)

SQUEEZE TYPE DISPENSER BOTTLES

Tega-Cort Forté and **Tega-Cort** lotions are offered in a nice smooth non-staining water soluble base.

Indications: For relief of the inflammatory manifestations of corticosteroiid responsive dermatoses including Poison Ivy, and sunburn.

Contraindications: Topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, or in large amounts, or for prolonged periods of time.

Dosage and Administration: Apply to affected area 3 or 4 times daily as directed by your physician.

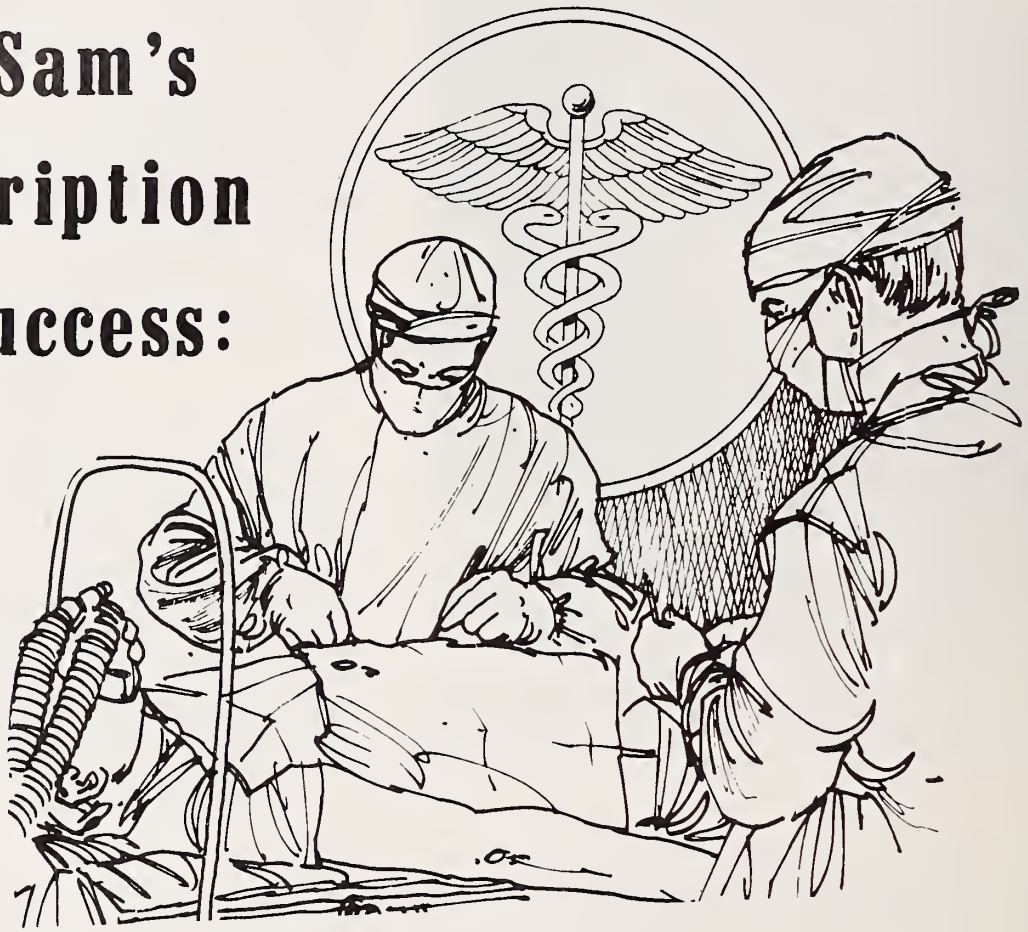
Caution: Federal law prohibits dispensing without prescription. For external use only. Store in a cool place but do not freeze.

PLEASE CONSULT INSERT SUPPLIED WITH EACH BOTTLE FOR MORE DETAILED INFORMATION

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

Uncle Sam's Prescription For Success:



Medicine and the Ga. National Guard

As a physician in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found...service to community, state and nation.

In addition, many persons have found that the change of place and change of pace have resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for the Georgia Army National Guard units. Physicians receive monetary support for attending approved CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. **WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS.** If you need that **CHANGE OF PLACE** and **CHANGE OF PACE**, contact:

ARMY NATIONAL GUARD
The Guard belongs.

Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

R ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

CHOPPER ONE



ICU 101



PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO

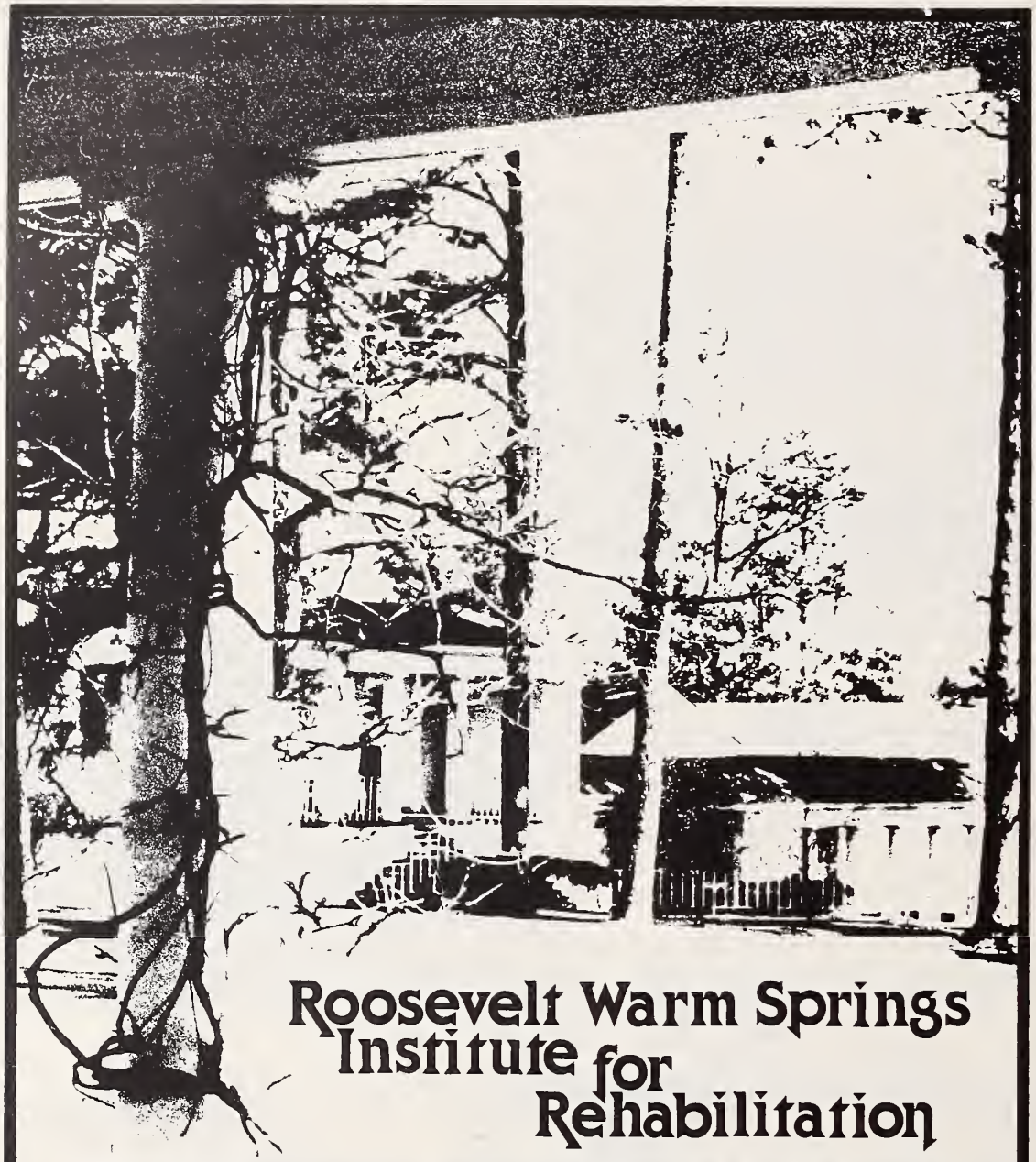
AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

CALL TOLL FREE

ORGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763



Roosevelt Warm Springs Institute for Rehabilitation

Continuing Comprehensive Rehabilitation Services for the medically stabilized patient who is ready for an intensive rehabilitation program.

● Medical Direction/Consultation ● Physical Therapy ● Occupational Therapy ● Rehabilitation Nursing ● Orthotics ● Speech Pathology ● Self Care ● Independent Living ● Rehabilitation Outpatient Clinic ● Vocational Training ● Psychology ● Program for Deaf-Blind ● Counseling ● Social Services ● Comprehensive Epilepsy Program

Referral by physicians, rehabilitation counselors, insurance companies
Costs vary with services; third party payments
For information call (404) 655-3321

Accredited by JCAH and CARF

THE NEW COLOSSUS

**Not like the brazen giant of Greek fame, with conquering limbs astride from land to land;
Here, at our sea-washed, sunset gates shall stand a mighty woman with a torch, whose flame is the imprisoned lightning, and her name, Mother of Exiles.
From her beacon-hand glows world-wide welcome; her mild eyes command the air-bridged harbor that twin cities frame.
"Keep ancient lands, your storied pomp!" cries she with silent lips.
"Give me your tired, your poor, your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost [sic] to me.
I lift my lamp beside the golden door!" — Emma Lazarus**

Shell Game on the Potomac

An attempt is being made to fool the American public. This time by the executive branch, which wants to quiet public fears over soaring inflation with a proposed package of budget cuts — coupled with tax increases.

Three facts stand out:

1. When you do the arithmetic carefully, the budget cuts will amount to zero.

2. The total effect of this budget maneuvering will be to give Americans the biggest peacetime tax boost in the history of the country.

3. If you take into account the so-called "off-budget" borrowing the government is already committed to, the true budget deficit will amount to over $60 billion.

The talk about a balanced budget is just another shell game on the Potomac.

Trick or Treat

The trick is accomplished by talking about budget cuts for fiscal years 1980 and 1981 and forgetting about budget "revisions" for the same years.

In fact, the Administration proposes to "revise" 1980 budget outlays upward by $6 billion and the 1981 outlays upward by $9.5 billion — a total of $15.5 billion.

That is the fine print, generally overlooked in the Administration's propaganda about budget cuts.

The big print calls for budget cuts of $2 billion in the 1980 budget and $13.5 billion in the 1981 budget. Total: $15.5 billion — or an exact offset of the revisions.

The real budget cut, therefore, is exactly nothing.

Balancing Act

Now look at taxes. As a result of various planned tax increases — including new withholding provisions and the oil import "fee" — taxes will rise from 20.5% of the gross national product in calendar year 1980 to 21.9% in calendar year 1981.

Because of the enormity of these tax increases, the budget will probably balance — but not as a result of the celebrated cuts of the Administration.

The budget will balance only because Americans everywhere will reach deeper into their pockets to pay for federal outlays that remain unchanged despite talk of "cuts."

Moreover, there is a notable anomaly in the tax situation that we should not overlook.

We have been told repeatedly by the Administration that OPEC increases in oil prices are responsible for inflation. Yet that same administration now plans to raise the cost of oil to the consumer as a supposed *solution* to *inflation*.

Surprise Package

We come now to the fanciest maneuver in the shell game — "off-budget" borrowing.

The bulk of the federal borrowing is not even included in the budget.

Several enterprises sponsored by government — like the Farm Credit Administration, the Federal National Mortgage Association ("Fannie Mae"), and the Government National Mortgage Association ("Ginnie Mae") — have the authority to borrow and lend independent [sic] of the budget.

Direct loans by such off-budget agencies grew 70% between 1976 and 1979 — two times the rate of growth of federal spending; and loan guarantees, which government also makes, increased by 108%.

So while the Federal Reserve is attempting to restrict credit as an anti-inflation device, the government itself is expanding credit through various means, thereby increasing credit enormously in 1981.

When all this off-budget credit is totaled, the *true* federal budget is a surprise package — it is actually 44% larger than it appears on the surface. And the true deficit for fiscal year 1981 will be $60.7 billion in nonbudgeted borrowing even if the budget balances.

Message for the Voter

What does all this mean? It means, in unvarnished language, that the American public is not being told the truth.

It means that once again the American public will foot the bill — the staggering bill — for an unbridled spending spree by the government bureaucracy.

It means that government is not truly in earnest about curbing the near 20% inflation that it has loosed through its own mismanagement.

It means, finally, that we citizens must work harder than ever to make sure that the men and women who represent us in government mean what they say when they say it — and will continue to mean it after they take office.

By the time you receive this message, other revisions of the budget may have been suggested by the Administration, and Congress will ultimately determine how much is appropriated.

I urge you to write to your elected representatives today about this new Potomac shell game, asking Congress to act on this matter and expressing your strong opposition to a continuation of the same spendthrift policies that are wiping out your buying power daily.

Robert F. Dee
Chairman of the Board and Chief
Executive Officer
SmithKline Corporation

(Editorial Note — In this month when we celebrate the anniversary of our country's independence, it seems appropriate to be reminded by the above editorial that our security and independence are being challenged from within our government by unrealistic economic policies.

Our only recourse to such policies is to use our considerable influence and demand that those whom we elect to serve us in Washington abide by the honorable principles upon which this nation was founded.)

Should MAG Start Its Own Professional Liability Insurance Company?

WITHIN THE NEXT few weeks, MAG members will be asked to express their views about whether or not the MAG should sponsor its own professional liability insurance company. You will receive materials outlining the pros and cons of such a company.

Accompanying these materials will be a brief questionnaire to determine the extent of your interest in and your willingness to support such a company. Those who are sincerely interested in the development of such a physician-owned company will be asked to demonstrate their support by enclosing a $100.00 check to undertake a full feasibility study on this project. This $100.00 will be credited towards a stock purchase in the company if one is formed.

This project is being undertaken at the direction of the MAG Board of Directors which at its January, 1980, meeting created an *Ad Hoc* Committee on Self Insurance, charged with investigating the possibility of MAG starting its own member-owned professional liability insurance company. The action was in response to a proposed substantial mid-year increase in premiums by The St. Paul Companies.

The Positive Side

In the past, MAG has had a mutually beneficial relationship with St. Paul. The rate of increase in premiums, however, has risen dramatically in the past 2 to 3 years. Several other factors have also precipitated MAG's consideration of starting a member-owned company. Presently, 21 medical society-owned companies exist, all of which seem to be successfully competing with commercial carriers. Four other medical societies are also looking into this possibility. Additionally, actuarial studies suggest the potential for substantial administrative savings which, coupled with interest on reserves for the company, offer a savings potential in premium costs of up to 25% and 30% after 3 to 5 years. Physician-owned companies also allow for closer physician participation in the screening of policy holders for risk management purposes. They also encourage more vigorous participation by physicians in claims management functions, thus insuring more direct control over operations of the company.

The Negative Side

There are potential problems, however, which must be considered. Members wishing to join the company would have to contribute approximately $2,000 to $3,000 each, the exact amount being determined by the number of physicians who joined. The company would also have to buy the "tail-end" liability coverage for unfiled suits resulting from actions when the members were insured with St. Paul. Additionally, the member-owned company would have to compete with St. Paul which is likely to remain in the state as a professional liability insurer. Finally, there is no guarantee that the company will survive, although no medical-society owned companies have to date gone out of business.

I urge each MAG member to read carefully the materials to be mailed by our *ad hoc* committee on this matter. Discuss them at county medical society meetings and consider seriously the potential benefits and problems of a physician-owned company.

This is one of the most important questions our Association will address this year. Please consider it carefully and discuss it thoroughly with your colleagues. Any one with specific questions should contact Bert Franco at MAG Headquarters.

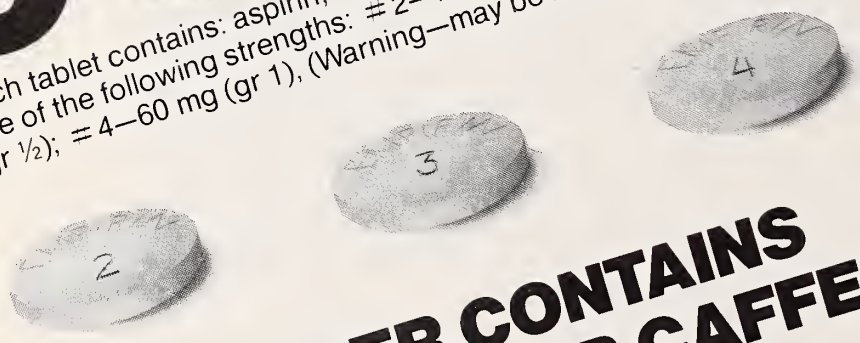
Charles D. Hollis, Jr., M.D., Albany
Chairman, Ad Hoc *Committee on Self Insurance*

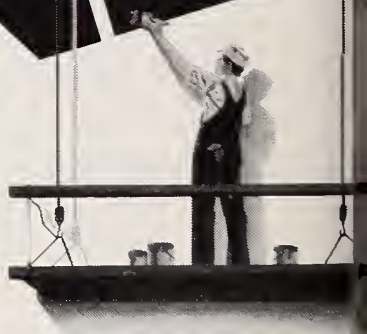
EMPIRIN® COMPOUND with CODEINE IS NOW

EMPIRIN® with CODEINE

Ⓒ III

Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: ≠2—15 mg (gr ¼); ≠3—30 mg (gr ½); ≠4—60 mg (gr 1), (Warning—may be habit-forming)





NO LONGER CONTAINS PHENACETIN OR CAFFEINE.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081



80%*

*__80%__ of the stocks recommended by Robert D.Carl, III, during the past three years have been profitable. More importantly, **95%** of closed positions have been profitable. Mr. Carl, Executive Vice President of J. Gatsby & Co., is solely responsible for all final decisions regarding stocks recommended in **THE NEW CONTRARIAN**, a stock advisor newsletter published twice monthly in Atlanta and advertised nationally in **BARRON'S.** He is also President of Carl Investment Associates, Inc., an investment advisor firm managing portfolios for individuals, corporations, pension funds and trust funds. While it cannot be assumed that future recommendations will be profitable or as profitable as past selections, a copy of Mr. Carl's performance record and **A WORD ABOUT CONTRARY INVESTING** may be obtained by writing J. Gatsby & Co.

THE NEW CONTRARIAN
published by
J. GATSBY & CO.
(registered with the S.E.C.)
is an **exceptional** securities newsletter.

30 DAY
unconditional
100% CASH REFUND GUARANTEE

☐ Enclosed is check for $165 for 1 year subscription.
☐ Enclosed is check for $95 for 6 months subscription.

Circulation Dept J Gatsby & Co
1054 First National Bank Building
Decatur Georgia 30030

Name _____
Address _____
City _____ State _____ Zip _____

Using Paraprofessionals as "Expert" Witnesses in Malpractice Cases

ROBERT N. BERG, *Atlanta**

SHOULD A NURSE be authorized to testify as an "expert" witness as to whether or not the actions of a physician were within the general scope of "accepted practice" in the medical profession? This question was recently answered in the affirmative by the Georgia Court of Appeals in a decision which could have significant ramifications in connection with the evidence required in professional malpractice cases.

Traditionally, in an action against a physician for malpractice, there is a presumption that the services performed by the physician were performed in an ordinarily skillful manner. The burden is placed on the patient to prove that the services were performed without the proper degree of care, skill, and diligence. In that context, it is the general rule in Georgia, as in most states, that it is not up to the jury to determine what is or is not proper medical or surgical treatment. Rather, it is ordinarily necessary that a plaintiff introduce the testimony of "expert" witnesses in order to establish (1) the appropriate standard of care, skill, and diligence exercised in the medical profession generally in connection with the particular services performed; and (2) that the services were performed by the physician in a negligent manner and not in accordance with those professional standards.[1] Until recently, the only witnesses deemed capable of proffering this "expert" testimony were physicians, most notably because they were thought to be the only ones with the training and experience necessary to provide meaningful testimony on the question of due care in medical malpractice cases.[2]

In *McCormick v. Avert,*[3] a patient brought a medical malpractice action against her physician, alleging that the radial nerve of her right wrist was injured as a result of the failure by the physician to exercise due care in keeping sterile a needle which was used to take a blood sample. The patient alleged that, after several unsuccessful attempts by the nurse to draw blood, the physician was called in and successfully withdrew blood from the patient's wrist area. Thereafter, the patient's wrist became irritated and subsequently infected, resulting in damage to her radial nerve. The patient testified that the hypodermic needle used throughout the several attempts to draw blood was never resterilized, the result of which was the infection to her radial nerve.

At the trial, the patient attempted to introduce the testimony of the nurse as an "expert" witness in order to show the proper procedure to be utilized in keeping a hypodermic needle sterile, and in order to rebut the presumption that the physician's actions fell within the scope of accepted medical practice. However, since

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

the nurse was not a physician, the trial court, relying upon the traditional evidentiary standards in medical malpractice cases (as described above), rejected the patient's attempt to use the nurse as the "expert" witness in order to rebut the presumption that the physician's actions constituted reasonable care.

On appeal, the Georgia Court of Appeals, in a split decision, reversed the trial court's decision, holding that the nurse could be qualified as an "expert" witness. The majority of the Court reasoned that, under the particular facts involved in the *McCormick* case, the nurse was "a licensed nurse who 'had drawn blood and given injections in numbers exceeding 2,000, and perhaps double that amount,' " and should therefore have been permitted to testify as an "expert" witness for the purpose of establishing the requisite standard of care for sterilizing hypodermic needles. According to the majority of the Court, since the procedure for keeping hypodermic needles sterilized did not require the special expertise and training of a physician but was a procedure for which a licensed nurse was "eminently qualified," the nurse should have been allowed to testify as an "expert" witness.

The Court was careful to limit its opinion, emphasizing that the testimony of the nurse related only to the proper procedure for keeping a hypodermic needle sterile, rather than to the proper standard for the actual drawing of blood or otherwise with respect to the diagnosis or treatment of an illness or injury. This limitation was delineated further in the special concurring opinion of Judge Shulman, in which he stated:

> "I do not wish to imply by this special concurrence, however, that in *all* instances where a paraprofessional and a professional perform the same function, e.g., withdrawing blood by use of a hypodermic needle, the paraprofessional can testify as an expert to the standard of care for the performance of that entire function. But, as to those elements of the performance of such functions for which the training of the professional is not required, a paraprofessional should be able to testify to the requisite standard of care for that particular phase of the function, but only in such extremely limited circumstances." (Emphasis in the original)[4]

In a strong dissenting opinion, Judge Birdsong indicated that he viewed the majority opinion as an unacceptable relaxation of the requirement in medical malpractice cases that medical testimony alone will suffice to furnish the necessary standard for a jury to determine what are the proper procedures in a particular treatment. According to Judge Birdsong, while the nurse in question was highly trained in the procedure of drawing blood and had received extensive education and training in that specialty, she was no better qualified to establish as an expert that the second use of a hypodermic needle without resterilization is not an accepted medical practice in the medical profession generally "than a practical nurse, a paramedic, a doctor's aid, or even a hospital administrator."[5] Rather, as stated by Judge Birdsong, "(i)t is inconceivable that anyone other than the members of the medical profession could establish the acceptable procedure for withdrawing blood from the human body."[6]

Despite the concerns expressed in the dissenting opinion, it now appears to be the law in Georgia that, at least in certain limited circumstances, a nurse may testify as to the standard of care which is utilized in the medical profession generally. From this, it is clear that the ramifications of the *McCormick* case are potentially significant, reaching beyond the health care area into other fields as well. For example, if a nurse can be qualified as an "expert" to testify as to what is or is not an accepted practice in the medical profession in connection with a malpractice action brought against a physician, then it is likely that other paraprofessionals can similarly be qualified as experts. Consequently, it may only be a matter of time before dental assistants are testifying as "experts" in connection with malpractice actions brought against dentists, and paralegals are qualifying as "experts" to testify as to the appropriate standard in connection with malpractice suits against attorneys.(*Write or call the* Journal *office for needed references.*)



SOME MALPRACTICE INSURANCE POLICIES SETTLE FOR JUST ANYBODY.

Today, all too many people are finding it easy to sue. And unfortunately, all too many insurance companies are finding it easier on themselves to settle. Quickly and out of court. Little thought is given to defending your reputation.

In fact, your insurance company may not even give you an option to fight a claim. Or if you do have that option, you can be hit with a costly penalty for going to court.

And there are other ways your insurance company may not stand behind you. For instance, chances are to save costs and time your company will use a claims adjuster to handle your case. Not a lawyer.

It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working hard for doctors. We know the strong coverage and knowledgeable service physicians need from their liability insurance. And because we specialize in this one field, we can offer a superior policy at a realistic premium. Premiums based on actual costs in your state.

Don't settle for just any insurance. Get a policy that really stands behind you. Contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas phone 1-800-231-2615.

ICA INSURANCE CORPORATION OF AMERICA

MALPRACTICE INSURANCE IS BETTER TODAY. BECAUSE OF ICA.

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

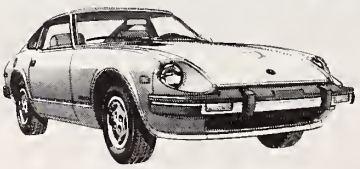
THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®



8-3305 (Y371A)



Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action **Triavil**®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

Copyright © 1980 by Merck & Co., Inc.

by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

Hepatic Resection for Metastatic Colon Carcinoma

ROBERT COWGILL, M.D., *Atlanta**

In two large medical centers employing an aggressive surgical approach to hepatic metastases from primary colorectal carcinoma, the 5-year survival rates have been reported to be 28% and 41% for synchronous and metachronous lesions, respectively.[1, 2] The most favorable subgroup of patients has a long disease-free interval and a small solitary metastasis. While major liver resections carried an unacceptable operative mortality 20 years ago, Dr. Joseph Fortner of Memorial Sloan-Kettering Cancer Center recently published his personal series of 108 major resections (79 of these had 50% or more of the liver removed) with a 30-day operative mortality of 9%.[3]

While published cure rates utilizing the standard methods for detecting recurrences are acceptable, they almost certainly will be dramatically improved upon with the wide usage of the carcinoembryonic antigen (CEA) test to detect recurrences too small to be seen on liver scan. Blood levels of this tumor marker are usually very high when colon cancer seeds the liver even though the primary malignancy may not have elaborated large amounts of the antigen. Current recommendations are to draw a CEA level pre-operatively and at least every 2 months for a year and a half following resection of the primary tumor, with determinations becoming less frequent after that and annually after 5 years. Because tumor burden correlates with the numerical CEA value, close monitoring of the test will enable us to detect early, small, resectable-for-cure lesions rather than late, incurable ones.

In their prospective study at Ohio State University, Minton and Martin found that three fourths of the patients had resectable disease (average CEA level in this group was 6.5 ng/ml) when the patients were monitored at monthly intervals, and the time delay between first elevation and laparotomy was minimized to 1.4 months.[4] Resectable recurrent disease was found in the pelvis, small bowel mesentery, and at the colonic anastamosis in addition to the liver.

What Operation Should Be Done For Hepatic Metastases?

Until recently, there has been controversy about the magnitude of the hepatic resection required for metastatic disease. The proponents of an anatomic right or left lobectomy felt that a better margin around the tumor could be achieved than with a wedge resection with less bile leakage and subsequent post-operative complications. Comparison of two series from the same institution, however, have failed to demonstrate superiority of the larger resection in terms of better survival

* Dr. Cowgill has taken leave from his oncologic surgery practice in Atlanta to practice in the King Faisal Specialist Hospital and Research Center in Riyadh, Saudi Arabia, for two years. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

figures.[1, 3] The consensus among doctors specializing in liver surgery is that the decision should be made at the operating table whether a lesion is sufficiently superficial to be resectable with an adequate margin of normal tissue using a wedge technique. Hopefully, CEA directed second look operations will enable us to utilize this lesser procedure more frequently than previously, when liver scans were relied upon to diagnose metastases, and the lesions had to be much larger to be detected. Although liver isolation cold perfusion techniques were being developed early in the 1970s in an effort to reduce operative mortality in major liver resections, these techniques have been abandoned in favor of normothermic hilar ligation and hepatic clysis. As Dr. Thomas Starzl stated in his discussion of Dr. Fortner's series, "it is clear that partial hepatic resection(s) has entered a new era of safety requiring no special gimmicks, nor anything other than the straightforward use of sound techniques and surgical principles. . . ."[3] With an arteriographic road-map, the hepatic artery, portal vein, and bile duct branches are ligated in the hilum, and electrocautery is used to divide the substance of the liver, cleaving it toward the vena cava with ligation of the appropriate hepatic vein(s) near the completion of the resection. As much as 85% of the liver substance is resected in the extended right hepatic lobectomy (trisegmentectomy) with preservation of the left lateral segment, the liver tissue to the left of the falciform ligament. Studies have shown that liver tissue begins to regenerate within a few days, and the process is usually completed in 6 months.[5]

Treatment of Multiple Hepatic Metastases

Surgical resection is not recommended when metastatic lesions are multiple. Chemotherapists are delivering single agent and combination chemotherapy systematically and locally via hepatic artery or portal vein catheters. There has not been sufficient success with any particular approach to recommend its exclusive use. A new technique for delivering radiation therapy via the hepatic artery using Yttrium-90 radioactive resin spheres has been developed by Dr. Edgar D. Grady of Atlanta and has shown promise in early clinical trials.[6] The procedure is done percutaneously and very little morbidity is associated with it.

Summary

The pessimistic attitude we have all developed in the past in treating far advanced metastatic liver disease should not carry over to deterring us from attempting to pick up recurrences from colorectal primaries early in their course. Close monitoring of the CEA test will enable us to operate sooner, and a significant improvement in cure rates should result.

References

1. Wanebo HJ, Semoglou C, Attiyeh F, Stearns MJ. Surgical management of patients with primary operable colorectal cancer and synchronous liver metastases. Am J Surg 1978; 135:81-5.

2. Wilson SM, Adson MA. Surgical treatment of hepatic metastases from colorectal cancers. Arch Surg 1976; 111:330-4.

3. Fortner JG, Kim DK, MacLean BJ, Barrett MK, Iwatsuki S, Turnbull AD, Howland WS, Beattie EJ. Major hepatic resection for neoplasia. Ann Surg 1978; 188:363-71.

4. Minton JP, Martin EW. The use of serial CEA determinations to predict recurrence of colon cancer and when to do a second-look operation. Cancer 1978; 42:1422-27.

5. Lin TY, Lee CS, Chen CC, Liau KY, Lin WSJ. Regeneration of human liver after hepatic lobectomy. Ann Surg 1979; 190:48-53.

6. Grady ED. Internal radiation therapy of hepatic cancer. Dis Colon and Rectum 1979; 22:371-5.

heart page
heart page
heart page

Heart Health Education For the Young, It's Important

JACK E. BIRGE, M.D., *Franklin**

THE DEATH rate from cardiovascular disease has declined. This important accomplishment has occurred mainly because of the dedicated efforts in prevention, early diagnosis, and treatment by many agencies and individuals. If what we have done in the past has saved lives, then we must do more, for the battle is far from won. Cardiovascular disease remains the number one cause of death in the United States. In order to know where we are going in the fight against cardiovascular disease, we must re-examine where we have been. Everyone agrees there are certain factors that contribute to the development of cardiovascular disease. Alter them, and the incidence of the disease will diminish. Since prevention is the ideal way of reducing infirmity and death from disease, a closer look is warranted at what can be done to eliminate factors contributing to cardiovascular disease. It is generally accepted that genetics, hypertension, serum lipid abnormalities, smoking, and obesity play major roles in the development of atherosclerotic cardiovascular disease. The role of exercise is still not entirely clear, but many believe a well-regulated program aids in the maintenance of good heart health.

Knowledge of these risk factors is not new. Neither is the need to do something about them, and many methods to combat this problem are under way. The Heart Health Education for the Young Committee of the Georgia Affiliate of the American Heart Association has established an educational program on cardiovascular risk factors with the goal to succeed by educational techniques where others have failed. It began in 1973. An educational curriculum on hypertension was developed and introduced in schools at the sixth, seventh, and eighth grade levels. Students were taught the essentials of cardiovascular anatomy and physiology along with basic facts about hypertension. They were taught how to take blood pressures and then went home with stethoscopes and sphygmomanometers to measure blood pressures of parents, relatives, and friends. The students were encouraged to share their new knowledge with them.

Two observations evolved. Interest in the program was phenomenal as demonstrated by students, parents, and teachers and it became evident that an effective method for the dissemination of important health care information, child to parent, was established. The program grew rapidly and has now spread to 120 of the 156 counties serviced by the Georgia Affiliate. The program also attracted national attention and is now being conducted in 29 other states across the nation. This year, it was cited as an exemplary health education program by the National Health Education Council.

* Dr. Birge is a family practice physician in Franklin. He is past-chairman of the American Heart Association, Georgia Affiliate, Heart Health Education for the Young Committee. Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

A curriculum on cardiovascular risk factors reduction followed. Students are taught the importance of proper diet and the dangers of serum lipid abnormalities, the importance of maintaining ideal body weight, and the dangers of smoking. The importance of exercise is also included. Demonstrative teaching techniques are utilized. This curriculum is now being implemented in approximately 60 Georgia counties. Enthusiasm among students and teachers has not diminished, and the success of this educational effort is expected to equal that on hypertension.

The ultimate goal of all health education programs must be to prepare our youth to become health maintenance minded. For one to properly care for his health throughout life, basic knowledge of prevention as well as certain disease must be attained. Risk factor alteration is a classic example of this point. Altering certain risk factors means altering life style; eating habits, not smoking, maintaining optimium body weight, etc. What better time to start than with the young and by what better method than through education? Risk factor curriculum in the schools will provide this knowledge. Then every person will be prepared to share a portion of the responsibility of maintaining their own cardiovascular health.

Physicians have the responsibility to see that quality health education is available to everyone, and their awareness of available programs is important.

Our committee solicits support of our program from the physicians of Georgia. It is a program that requires little time, but your endorsement is an important motivating force for the establishment of the program in your community. Contact your local heart unit of the American Heart Association, Georgia Affiliate, and express your support. They can do the rest in getting the program established.

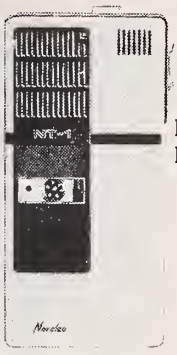
In 1980, twenty-eight thousand students from 300 schools in 120 counties will be taught about the risk factors of atherosclerotic cardiovascular disease. Our goal is to teach every student in the state of Georgia. With help from the physicians this can be attained.

In addition, the committee is collecting data regarding childhood blood pressures. The frame work of this program provides the ability to measure blood pressures of children across the state on a massive scale and follow them from year to year. Perhaps we may discover significant patterns of blood pressure alterations in children that will indicate which ones will become the hypertensives of adulthood and with this knowledge, learn more of the origin of hypertension and how to reduce its complications.

The Complete Communication Company...

OFFICE COMMUNICATIONS INCORPORATED*

e Portables



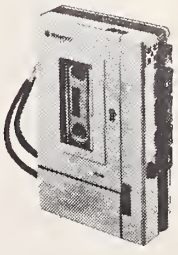
NORELCO
NT-1



NORELCO
185

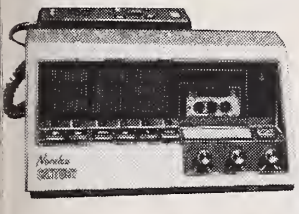


DORO
706



SANYO
1500

Desk Top Dictation/Transcription Systems



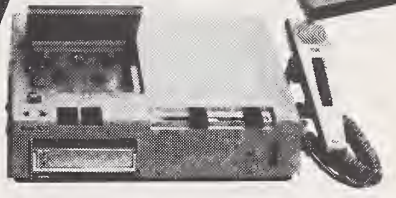
NORELCO
CENTURY



DORO 707



NORELCO 102



DORO 705

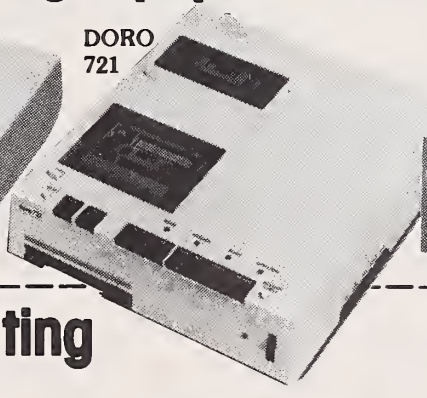


NORELCO 186

Phone Answering Equipment



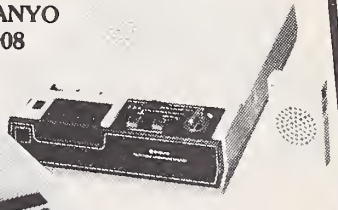
SANYO
139



DORO
721



DORO
320

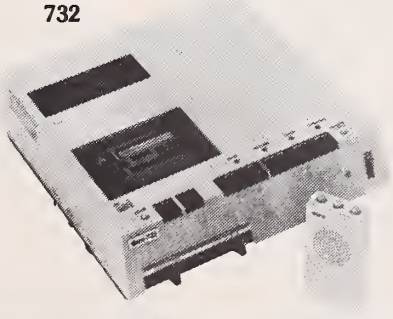


SANYO
9908

Telephone Dictating



NORELCO
260



DORO
732

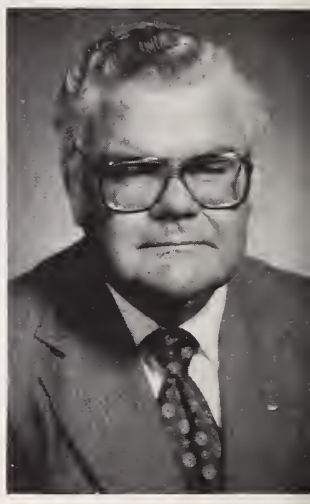
*One Stop Communications Sales and Service...

OCI offers you the finest quality and performance in dictation and transcription equipment from respected names in the industry: Norelco, Sanyo, and Doro. There are none better and our complete lines of this equipment from pocket size portables to Automatic Phone answering and Dictating Systems are offered to you along with complete service department throughout Georgia. Just call our Atlanta office (404) 448-8741 for your nearest One Stop Office Communications sales representative.



OFFICE COMMUNICATIONS INCORPORATED
6575 Peachtree Industrial Blvd./Norcross, Ga. 30092 (404) 448-8741

president's letter



Membership — A Top Priority

THERE MUST BE considerable concern to every MAG member when some 1500 physicians in Georgia choose not to spend 62¢ a day to join the Medical Association of Georgia, and thus participate in preserving the freedoms of our profession.

It should be of distressing concern to those 1500 Georgia physicians who elect to ignore the reality that for about $2.50 a day — including county, MAG, and AMA dues — organized medicine is a bargain.

Realistically, it is a fact that at our county, state, and national levels, our profession's interests and rights are daily being defended — including the interests and rights of those who opt not to pay dues to support these efforts.

All physicians in Georgia, including those who do not join and do not pay dues, benefit directly from the wide range of activities promoted by MAG in protecting our principles.

The budget-making process of the MAG regularly receives lengthy, intelligent, and deliberate review. It is a sound and fiscally responsible budget.

If our 1500 colleagues who are eligible to join would do so, a potential dues increase in 1981 could be avoided.

We need all physicians to be actively supportive of organized medicine. We must have that support if we are to continue to protect and defend our profession and our patients.

In all candor, I do not see how anyone can honorably enjoy the rights and reap the benefits without accepting the responsibilities and paying their dues.

Obviously, these facts are directed to Georgia physicians who are not MAG members.

Yet I know of no other way to solicit new membership, except by personal contact.

It is my sincere hope that every MAG member will actively participate in our membership goals.

Quality membership — in unity and in numbers — is a top priority.

Respectfully,

H. Hilt Hammett Jr., M. D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

NEW MEMBERS

Badaruddin, Rose B., DeKalb—N2—PD
4759 Rockbridge Rd., Stone Mountain 30083

Bolch, Sidney J., Georgia Medical Society—N2—CD
5 St. Joseph's Professional Plaza, Savannah 31406

Carson, Harold B., Oconee Valley—ACT—FP
520 Sibley Dr., Union Point 30669

Christmas, Robert C., Cobb—N2—OBG
553 Cherokee, Marietta 30060

Collier, Craig B., Gordon—S—FP
Professional Bldg., Red Budd Rd., Calhoun 30701

Hammond, William J.,
Ben Hill-Irwin—ACT—OBG/SU
P. O. Box 929, Fitzgerald 31750

Hicks, Walter L., Jr., Glynn—ACT—EM
Glynn-Brunswick Memorial Hospital, Brunswick 31520

Miller, Robert H., Glynn—ACT—EM
Box 1518, Brunswick 31520

Price, John W., Cobb—ACT—FP
814 New Spring Rd., Atlanta 30339

Thuman, Monty, Laurens—N2—FP
Medical Center, Dublin 31021

PERSONALS

Second District

Edward S. Armstrong, M.D., of Albany, has retired om practice.

To feature National Hospital Week, several Thomas-lle physicians from Archbold Hospital presented a panel rogram entitled, "What's New in Medicine in Thomas-lle." **A. A. Zavaleta, M.D.,** a general thoracic and ascular surgeon served as moderator. **Gerald Kadis, I.D.,** a neurosurgeon, was a panelist.

Third District

The Terrell County Hospital Authority paid tribute to **harles Ward, M.D.,** of Dawson, for 25 years of service the hospital and community. He was honored by having portrait hung in the hospital's visitors' room.

Fourth District

H. Hutson Carspecken, M.D., of Atlanta, has been ected a trustee of the Southeastern Society of Plastic and econstructive Surgeons.

Lawrence Freeman, M.D., of Chamblee, has been appointed to a second term on the Board of Directors of the North Central Georgia Health Systems Agency.

The Alumni Association of Emory University recently presented the Award of Merit to **Olan Wytch Stubbs, Jr., M.D.,** of Decatur. The award was presented in recognition of his outstanding service to the University.

Fifth District

On May 5, **E. Garland Herndon, Jr., M.D.,** Vice President for health affairs of Emory University in Atlanta and Director of Emory's Woodruff Medical Center, received the Woodruff Award for Dedication at a dinner in his honor.

Sixth District

The *News-Gazette* of Barnesville honored **John Crawford, M.D.,** with an article devoted to his professional and private life.

W. Stephen Taunton, M.D., of Butler, has been elected Chief of Staff of Family Practice at the Medical Center of Central Georgia in Macon.

Macon urologist, **Cassius M. Stanley, III, M.D.,** has opened a second office in Warner Robins.

S. B. Traylor, M.D., of Barnesville, was honored with an article in that town's *News-Gazette* for his 50 years of practice.

At the recent Enoch Callaway Cancer Clinic seminar, the American Cancer Society presented **Hoke Wammock, M.D.,** of LaGrange, with a silver bowl. The award was given in appreciation for his work at the E. Callaway Cancer Clinic.

LaGrange surgical oncologist, **J. Thomas West, M.D.,** recently returned from a 5-week medical mission tour to Zaire.

Seventh District

Joseph G. Bussey, Jr., M.D., of Austell, recently returned from a trip to the Boston area where he spoke at several hospitals on the use of transcutaneous electrical nerve stimulation (TENS).

Two MAG members have recently opened practices in Calhoun, **Jack Gent, M.D.,** and **Craig Collier, M.D.**

Sahin S. Kocacitak, M.D., a native of Ankara, Turkey, recently opened a family practice in Rossville.

Ninth District

John W. Garland, III, M.D., of Gainesville, was recently elected president of the Georgia Psychiatric Association.



Under the auspices of the Legislative Committee of the Medical Association of Georgia, MAG representatives made their 21st annual visit to Washington, D.C., to meet with members of Georgia's Congressional delegation. Following a tradition that began in 1959, a key physician from each Congressional District went to serve as personal host for his Congressman to help maintain MAG's carefully cultivated rapport with those who represent us. The AMA Washington staff conducted an intense briefing session for MAG members on pending legislation of significant interest to the practicing physician.

The members of the Senate and House delegations from Georgia were honored at a luncheon in the Capitol (above photo) given by the MAG. MAG members attending were: H. Hilt Hammett, Jr., LaGrange, MAG President; James A. Kaufmann, Atlanta, Legislative Committee Chairman; John M. Martin, Augusta; Earnest C. Atkins, DeKalb County, Immediate Past President; Charles D. Hollis, Albany; O. Wytch Stubbs, Decatur; Louis Sullivan, Atlanta; Ronald H. Koenig, East Point; John I. Dickinson, Rome; Beverly Sanders, Macon; Ralph Tillman, DeKalb County; and Harrison Rogers, Jr., Atlanta, Vice Speaker of the AMA House of Delegates.

On May 14, as a part of the Northeast Georgia Medical Center's community health education program, **Sam Poole, M.D., Thomas Woodrow, M.D.,** and **W. D. Stribling, M.D.,** of Gainesville, conducted a panel discussion on heart disease and its prevention.

Tenth District

Gary N. Harrison, M.D., of Savannah, was recently elected a Fellow of the American College of Physicians.

DEATHS

Arthur C. Primrose

Arthur C. Primrose, M.D., 85, of Americus, died April 30.

A native of Springfield, Illinois, Dr. Primrose practiced medicine in Americus for over 50 years. He graduated in 1920 from Johns Hopkins University School of Medicine. He was an honorary member of the Americus Kiwanis Club and a member of Calvary Episcopal Church.

He is survived by one daughter, a granddaughter, two grandsons, and two great grandchildren.

Arnold Neistadt

Arnold Neistadt, M.D., 45, of Atlanta, died Tuesday, May 13.

Dr. Neistadt received his M.D. degree from Harvard University Medical School. He was chief of staff at Windy Hill Hospital, Marietta, and also on the medical staffs of Northside, St. Joseph's, and Shallowford hospitals. He was a Fellow in the American College of Surgeons and a member of the International Cardiovascular Society. A photographer and scuba diver, Dr. Neistadt was vice president of the International Society of Aquatic Medicine. He was a member of Congregation Shearith Israel.

Survivors include his wife, two daughters, parents, and a sister. A Memorial Fund has been created in his honor to be used for an educational lecture in medicine. Please send contributions in lieu of flowers to this Fund, 2550 Windy Hill Rd., Ste. 208, Marietta, GA 30067.

Donarell Rhea Green, Jr.

Donarell Rhea Green, Jr., M.D., 71, who practiced in Athens for more than 30 years, died Friday, May 30.

A native of Atlanta, Dr. Green received his M.D. degree from Meharry Medical College in 1942. He served as an intern before entering the army where he earned the rank of captain during World War II.

In 1936, Dr. Green began his practice in Athens. He was owner and administrator of Susan Medical Center, and was staff physician and medical consultant for the Athens Neighborhood Health Center, Inc., from 1973 to 1978.

His professional recognitions include a Certificate of Merit from St. Mary's Hospital, the Kappa Alpha Psi Award, a 100 Percenter Award, and an Outstanding Citizenship Award in 1977.

Survivors include his wife, two sons, and four daughters.



WHEN ANXIETY AND TENSION MAGNIFY PAIN IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® C-IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved

*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® ℂ℣

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require caretul titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and halt-life may be usetul in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa 19101

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from March through May 1980.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Earl Lewis Alderman, Atlanta
Henry M. Althisar, Augusta
Blanca R. Anton, Decatur
Thomas Seymour Arnold, Augusta
Manuel Enrique Artime, Decatur
Bertram Price Avera, Dublin
Stephen Michael Barnett, Atlanta
Glenn Hughes Bartlett, Hartwell
Donald Sims Bickers, Atlanta
John Pope Boineau, Augusta
Richard Michael Boozer, Atlanta
John Bostwick, Atlanta
Jimmy Sheppard Brown, Atlanta
Robert Eugene Clayton, Columbus
Rudolf Albert Colmers, Savannah
Jose Fernando Cordero, Atlanta
William Dukes Crawley, Rossville
Howard C. Derrick, LaFayette
Charles E. Dowman, Atlanta
John Gresham Durden, Columbus
Winlove Pabellan Eduarte, Atlanta
John Sanford Evans, Atlanta
Bernardo Pedro Fernandez, Dublin
Edmund M. Fitzgerald, Dublin
Arvind M. Bowdon Gadhia
Brinton B. Gay, Decatur
Bijan Ghorashi, Marietta
Robert Thornton Goetzinger, Marietta
Dilip Eknath Gole, Hinesville
Francisco E. Gonzalez, Canton
James Franklin Green, Villa Rica
Herbert S. Greenwald, Macon
George Travie Henry, Barnesville
E. Rawson Griffin, Fort Benning
David Richardson Haburchak, Fort Gordon
Sterling Adair Harris, Buford
David Hleap, Cumming
Jeff J. Holloman, Savannah
Douglas Edward Howell, Jesup
George Baker Hubbard, Columbus
Paul Hutchinson, LaGrange
Anthony Frank Isele, Albany
William D. Jennings, Augusta
Charles W. Johns, Macon
Janet King Johnson, Dahlonega
Tae Won Kim, Albany
Henry Milton Labiche, Columbus
Dixon Alexander Lackey, Atlanta
Samuel Robert Lathan, Atlanta
John Everett Lee, Atlanta
Sidney Reaves Lee, Atlanta
Peter Brynan Leff, Decatur
Matthew Edward Levine, Augusta
George H. Longley, Augusta
William Doyle Lowery, Albany
Malcolm N. Luxenberg, Augusta
Louis O. J. Manganiello, Augusta
Kamal A. Mansour, Atlanta
Mohammad Ali Masroor, Savannah
Milton Mazo, Savannah
Jack Reeves Meacham, Summerville
Gail Dietrich Miller, Augusta
Puthugramam K. Natrajan, Columbus
Mehmet Hikmet Nazli, Austell
Lyle Alfred Norwood, Columbus
Carlos A. Osmon, Austell
Harry Parks, Atlanta
Alan Stephen Peiken, Columbus
Edwin Noel Preston, Chamblee
Dent Wiley Purcell, Savannah
Morgan Burgess Raiford, Atlanta
Frank Arthur Raila, Dublin
Lawrence A. Rathbur, Savannah
Mario Ravry, Jr., Atlanta
Derrell Wayne Ray, Atlanta
Paul F. Richin, Decatur
John Charles Rieser, Atlanta
Seaborn A. Roddenbery, Columbus
Julius T. Rucker, Augusta
Floyd R. Sanders, Decatur
Benjamin Franklin Sawyer, Savannah
Elbert William Schmitt, Atlanta
Ronald Oliver Schwartz, Albany
James William Scott, Tifton
Hugh Key Sealy, Macon
Perry Gray Seese, Atlanta
Ivy Lee Shuman, Sylvania
Stuart Eugene Sims, Atlanta
Oliver Allen Sorsdahl, Atlanta
David S. Sowell, Hapeville
Thomas Maury, Stanley, Savannah
Franklin Julian Star, Columbus
Eddie Clay Starnes, Fort Gordon
Richard McBee Stewart, Gainesville
James Mason Tallman, Marietta
Thomas Matthew Tamblyn, Savannah
Chandrika B. Thakrar, Demorest
Nathaniel A. Thornton, Atlanta
Richard Prescott Torp, Atlanta
Chuong Dinh Tran, Augusta
William Trevejo, Thomasville
Corbett Harold Turner, Atlanta
Lourdes Nery Vallejo, Stone Mountain
Rita Gidwani Wadhwani, Rome
William Michael Walsh, Columbus
Paul Frederick Walter, Decatur
John L. Williams, Augusta
Tom Vann Willis, Brunswick
Howard Sanford Yager, Atlanta
Sidney H. Yarbrough, Columbus
George Zubowicz, Columbus

Peachford Hospita
A uniquely positive, comprehens

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge.

Twenty-four hour admittance is offered for all programs.





MEDICAL SERVICE DIRECTORS

BOAZ HARRIS, M.D.
Medical Director

CONWAY HUNTER, JR., M.D.
Director, Addictive Disease Unit

CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

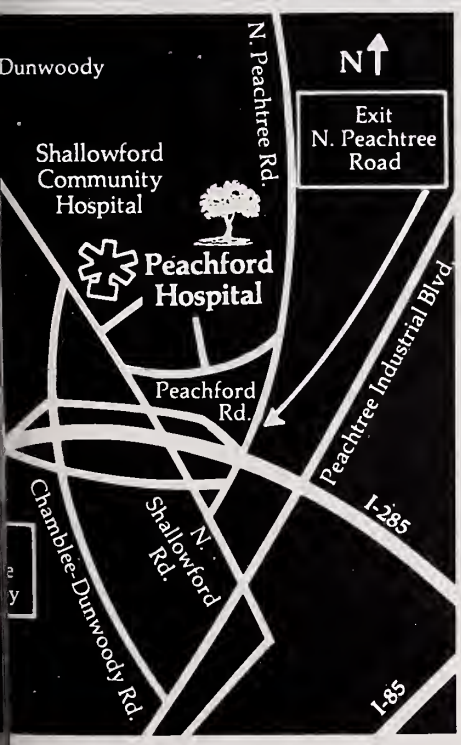
JOHN B. HARDMAN, M.D.
Director, Children's Unit

ogram of recovery...that's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

ete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/ Atlanta, Georgia 30338
Phone (404) 455-3200





Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS
(mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

©Janssen Pharmaceutica Inc 1980

JPI-023



Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Index to Advertising

Vol. 69 July 1980 No. 7

Ballard, Walter, Optical Company 643

Boots Pharmaceutical, Inc. 605-608

Brawner Psychiatric Institute 619

Burroughs Wellcome Company 618

Classifieds 645

Decatur Hearing Aid Service 603

Dickey-Mangham Company 643

Electric Research Corporation 604

Fulton Federal Savings and Loan Association 580

Gatsby, J., and Company 620

Georgia National Guard 612

Georgia Rehabilitation Center 614

Global Imports 645

The Great Cherokee Trading Company 624

Hickman-Datsun 624

Insurance Corporation of America 623

Janssen Pharmaceuticals 642, 643

Lilly, Eli, and Company 596

MAG Scientific Assembly 584

Merck, Sharp, & Dohme 626-628

Merrell-National, Inc. 586, 587, 624, 625

Metro Ambulance 613

Office Communications, Inc. 633

Ortega Pharmaceutical Company, Inc. 611

Peachford Hospital 640, 641

Peachtree and Parkwood Mental Health Center and Hospitals 583

Potter-Holden and Company 586

Psychiatric Institute of Atlanta 582

Ridgeview Institute 646

Roche Laboratories 578, 579, 580, 588, 647, 648

Weight Watchers of Greater Atlanta 586

Willingway Hospital 600

Wyeth Laboratories 637, 338

JOURNAL
of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

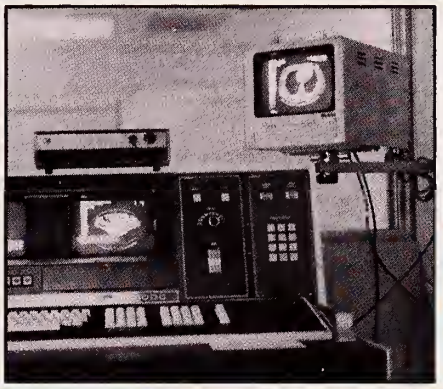
ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands of its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

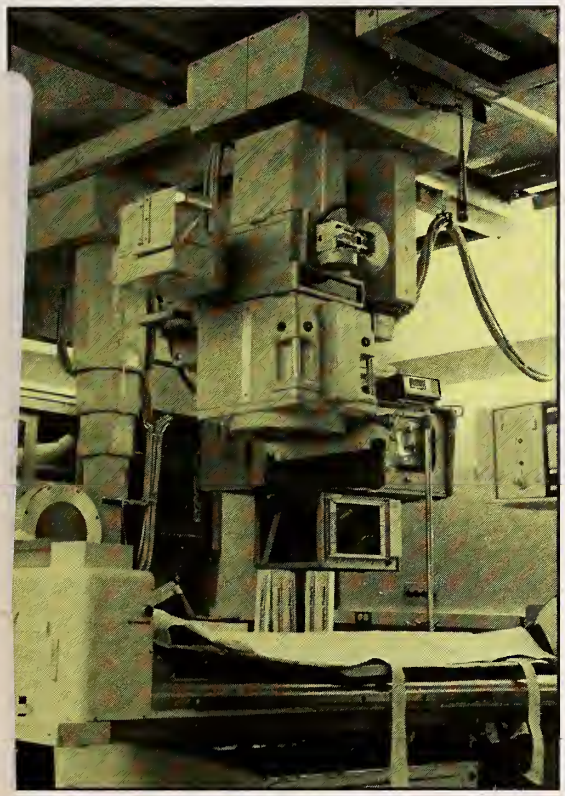
ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc. to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

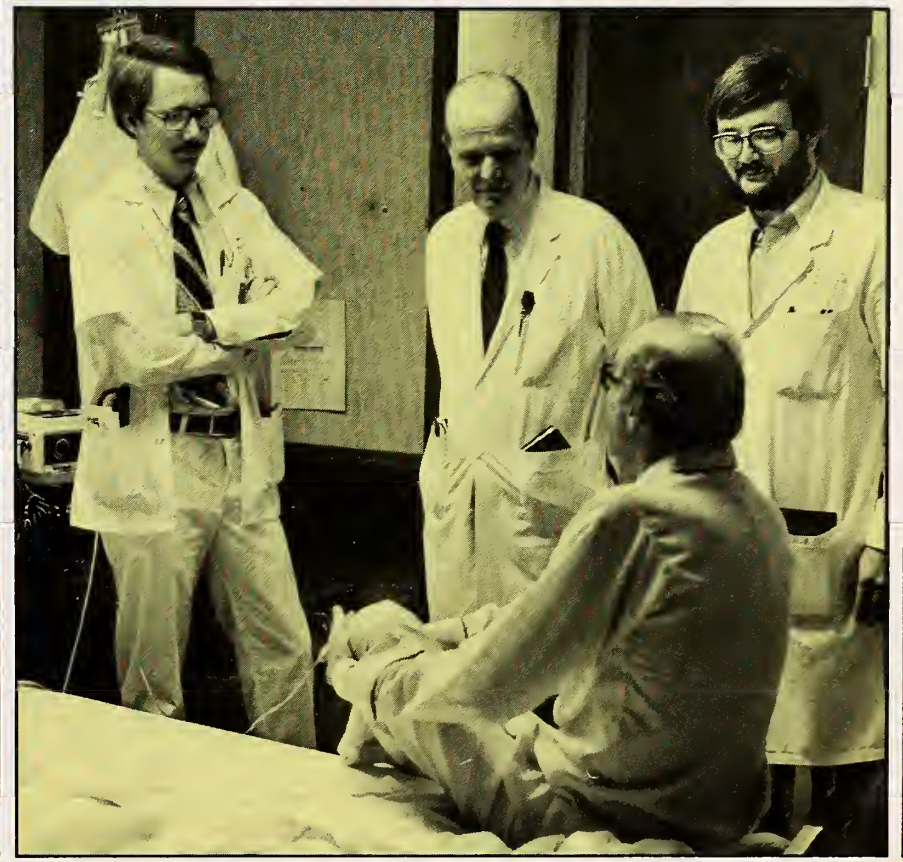
MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

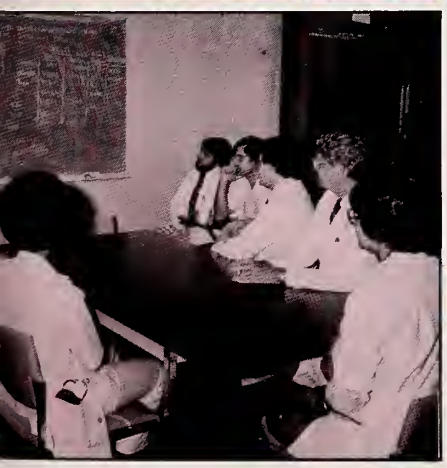
JOURNAL
of the medical association of
georgia
ISSN·0025·7028 AUGUST / 1980

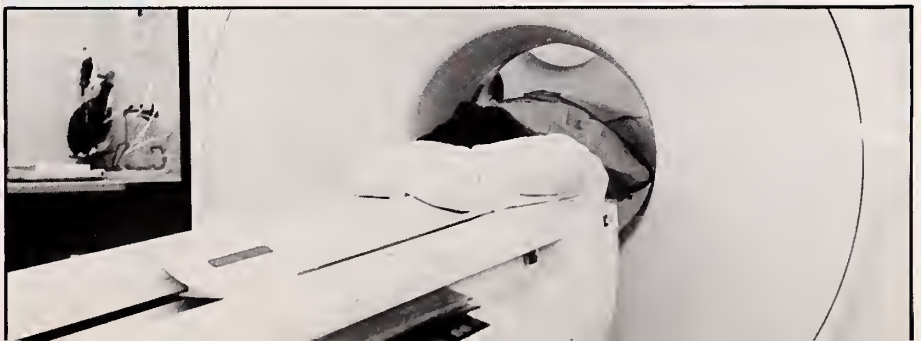


CME



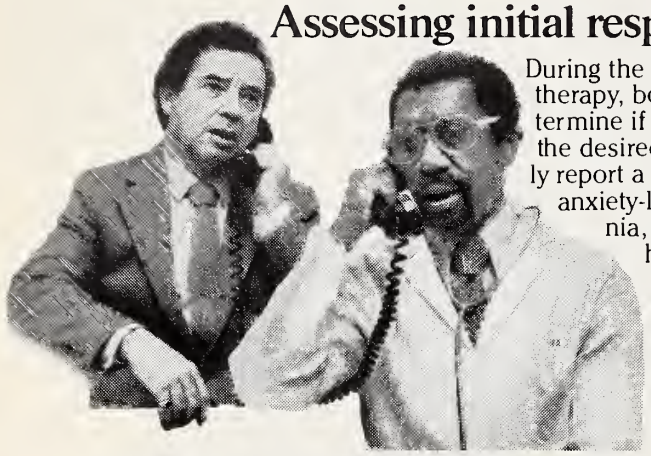






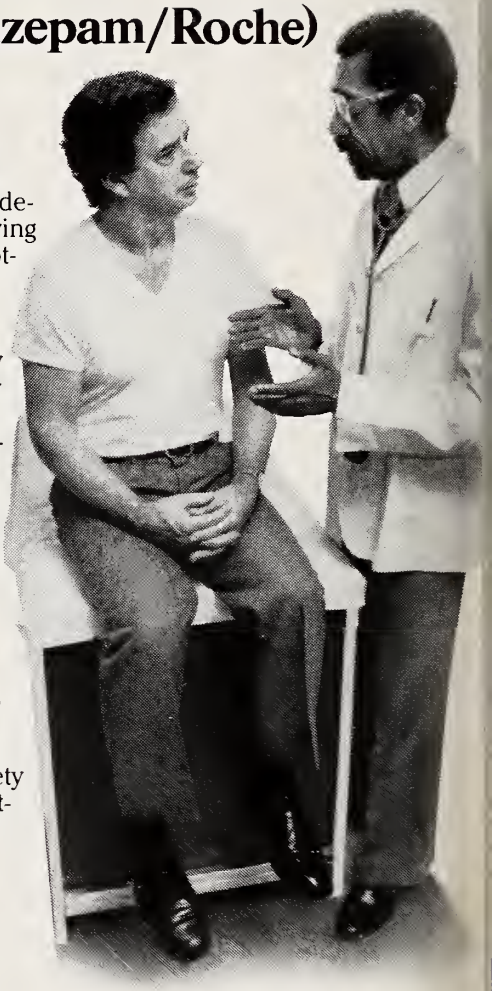
SEP 3 1980

Monitoring patient response to Valium® (diazepam/Roche)

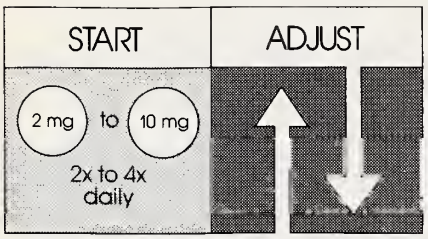


Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments



With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

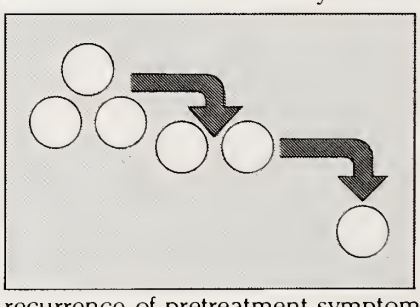
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention

When you decide to discontinue therapy, tapering dos is good medical pract Although rarely nec- essary after short-term treatment with Valium gradual dosage reduc is advisable for patien who have been on ex- tended therapy. This g ual discontinuance should preclude eithe recurrence of pretreatment symptoms or development of u toward side effects. Symptoms of withdrawal have almost a ways been associated with abrupt discontinuance of therap higher dosages taken continuously over long periods of tim



2-mg, 5-mg, 10-mg scored tablets

Valium® (IV)
diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

ROCHE®

See the following page for a summary of product information.

Valium® (diazepam/Roche) ℞

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

ROCHE®
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Office Equipment

Vacation Opportunities

Physicians Wanted

Recreational Equipment

Art 'n Antiques

Rental Property

If you want to buy an antique car . . . or sell a lucrative practice, or lease some prime office space or hire another associate, use the *Journal*'s **Classifieds** to get your message to thousands of physicians in the metro Atlanta area and around the state.

Journal Classifieds

Reaches the Georgia Physician



People Who Care About People

Brawner
Psychiatric Institute

3180 Atlanta Street, S.E., Smyrna, Georgia 30080 Telephone: 404/436-0081

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 8

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director
Joyce Butler, R.N., Assistant Executive Director
J. Tom Sawyer, Assistant Executive Director
Kenneth M. Williams, Director of Public and Professional Relations
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

699 Smoldering DIC Associated With Widespread Colonic Mucinous Adenocarcinoma
J. S. Krauss, M.D.
C. R. Baisden, M.D.
L. B. Otkin, M.D.
O. E. Talledo, M.D.
704 Oral Diabetic Agents: More Dangerous in the Elderly Than Recognized
George S. Walker, III, M.D.

SPECIAL ARTICLES

663 Medicine: It's a Beautiful Story
Hoyt D. Gardner, M.D.
668 Biofeedback Therapy in Clinical Practice
Stanley L. Chapman, M.D.
V. R. Rao, M.D.
673 The School of Medicine at Morehouse College: Status in 1979 and Plans for the Future
Louis W. Sullivan, M.D.

EDITORIALS

719 The Round Peg, Square Hole Syndrome
Carl L. Rosengart, M.D.
721 Smoke-Free Hospitals — The Time Has Arrived
Sheldon B. Cohen, M.D.

FEATURES

711 Legal Page/The Confidentiality of Medical Review Committee Proceedings Under the Georgia Law
Robert N. Berg
Dennis L. Zakas
723 Heart Page/Transluminal Coronary Angioplasty
Arnoldo Fiedotin, M.D.
725 Cancer Page/A General Surgeon Looks at Breast Reconstruction
Charles R. Underwood, M.D.

THE ASSOCIATION

654 Letters to the Editor
674 CSBME Disciplinary Actions
679 Preliminary Program for the 1980 Scientific Assembly
715 President's Letter/Let's Stay Cool — But Involved
H. Hilt Hammett, Jr., M.D.
717 New Members
717 Personals

INCIDENTAL INTELLIGENCE

656 Communications Workshop for Auxiliary
658 State Heart Association Names News Officers
658 Who Smokes?
658 Georgia Chapter of the American Association of Medical Assistants Holds Its Annual Meeting in Valdosta
659 Medical Malpractice Insurers Need to Cooperate
660 Medical Meeting Calendar

THE COVER

CME — Continuing Medical Education — is the primary purpose of the MAG Scientific Assembly to be held in Atlanta in November 1980. The Preliminary Program for the Scientific Assembly featured in this issue gives you an opportunity to become familiar with the wide variety of programs offered. We encourage you to register early. Cover photographs by Joe Jackson from the Department of Medical Illustration at Emory University; cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Letters to the Editor . . .

MEDLAR

Dear Sir:

Please let me express my appreciation to authors, Ms. Timm and Doctors Silverman and Davies, for their interesting, brief article on "Computerized Literature Search in the Community Hospital" in the May *JMAG*.

This type of shared experience is very helpful to those of us interested in continuing medical education, and is typical of the leadership that Piedmont Hospital has offered in the area of medical, para-medical, patient, and public health education.

While MEDLAR may be somewhat of a luxury at present, it is my opinion that its use will be essential in the future.

Sincerely yours,
LaMar S. McGinnis, M.D.
Atlanta

Journal Award

Dear Sir:

Congratulations on receiving the Sandoz Journalis Award for being the best state medical journal in th country. Your staff did an outstanding job. The quality o the *Journal* has been extremely good in the last few year and I am glad that others recognized this. I trust you wi not hide your light under a bushel and will let the mem bership of the MAG know about this.

Sincerely,
Nicholas E. Davies, M.D.
Atlanta

Introducing...

TEGA-CORT FORTÉ 1% - TEGA - CORT - 0.5%

(Available at all drug stores - Rx Only)

SQUEEZE TYPE DISPENSER BOTTLES

Tega-Cort Forté and **Tega-Cort** lotions are offered in a nice smooth non-staining water soluble base.

Indications: For relief of the inflammatory manifestations of corticosteroiid responsive dermatoses including Poison Ivy, and sunburn.

Contraindications: Topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use in pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, or in large amounts, or for prolonged periods of time.

Dosage and Administration: Apply to affected area 3 or 4 times daily as directed by your physician.

Caution: Federal law prohibits dispensing without prescription. For external use only. Store in a cool place but do not freeze.

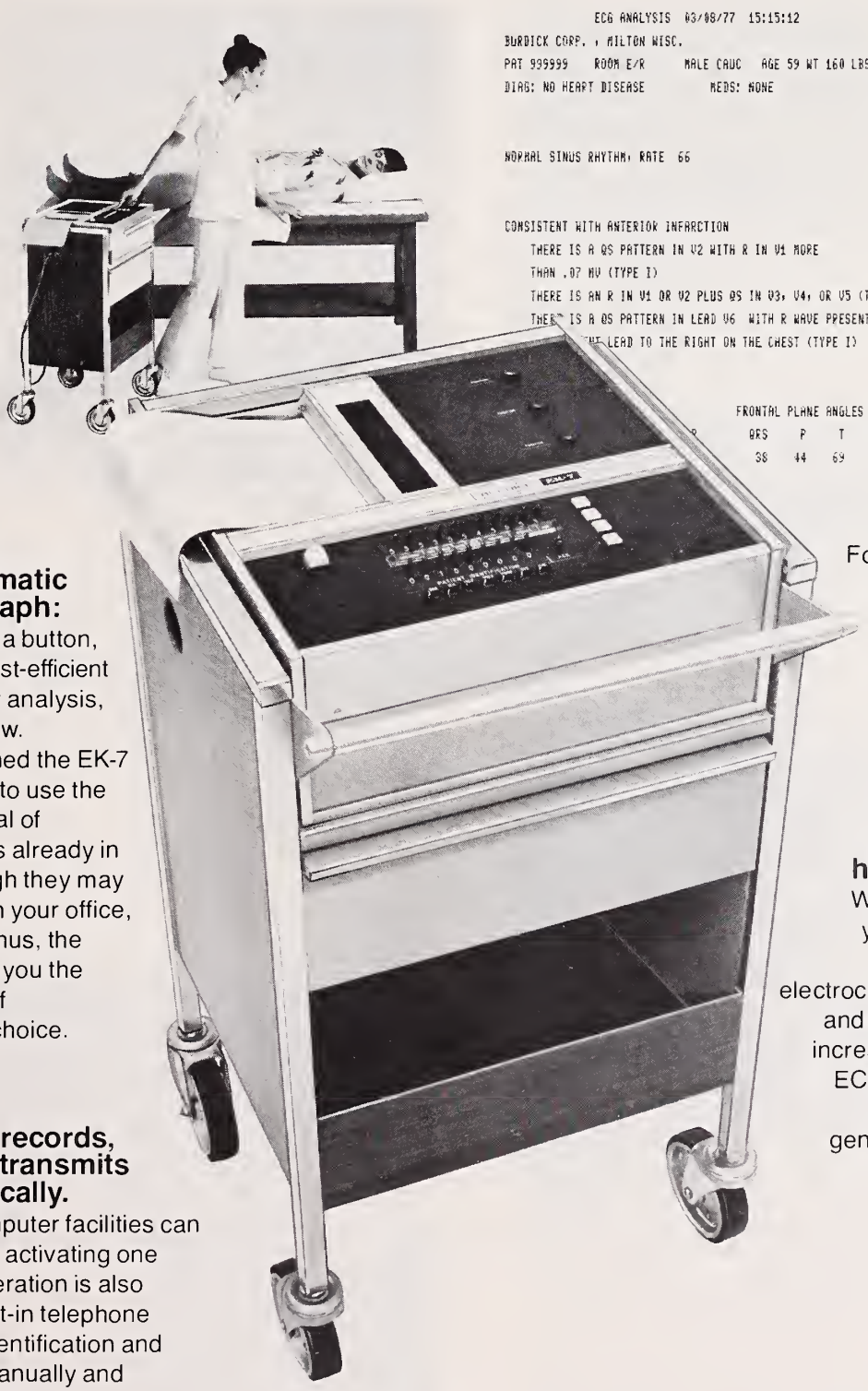
PLEASE CONSULT INSERT SUPPLIED WITH EACH BOTTLE FOR MORE DETAILED INFORMATION

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

Burdick's new EK-7:

Today's intelligent answer for computerized ECGs.



rdick's new hannel automatic ctrocardiograph:

At the touch of a button, EK-7 provides cost-efficient Gs for computer analysis, dy for your review.

Burdick designed the EK-7 uisition system to use the rpretive potential of puter programs already in ice, even though they may nany miles from your office, c or hospital. Thus, the dick EK-7 gives you the atest freedom of puter-service choice.

dick's EK-7 records, nslates, and transmits Gs automatically.

Access to computer facilities can s automatic as activating one on. Manual operation is also sible with a built-in telephone dset. Patient identification and stics are set manually and smitted automatically.

For immediate examination, you get scratch-resistant, smudge-free tracings, produced on Burdick's easy-to-read BlueTrace 3-channel paper.

Burdick and computer-assisted electrocardiography help meet your needs.

When you invest in an EK-7, you invest in your practice. Computer-assisted electrocardiography substantiates and augments your diagnosis, increases speed and volume of ECGs administered. For your review, you get computer-generated ECG interpretation in minutes.

Electric Research Corporation

1399 DUTCH VALLEY PLACE, N.E. • TELEPHONE 873-1084
ATLANTA, GEORGIA 30324

Incidental Intelligence . . .

Communications Workshop for Auxiliary



Ann Satcher (Mrs. Milton B.), President of the Auxiliary to the MAG, and Mr. Bruce Glover, representative of the Burroughs-Wellcome Company helped plan the Communications Workshop for Auxiliary members at Callaway Gardens.



David Reynolds from Burroughs-Wellcome Company in North Carolina speaks to Auxiliary members about techniques of interviewing physicians on various health matters and how to get the taped interviews programmed on their local radio stations.

Auxiliary members of the Medical Association of Georgia (MAG) attending their summer board meeting at Callaway Gardens, June 17-19, participated in a Communications Workshop conducted by the Burroughs-Wellcome Company. The purpose of the workshop was to educate a cadre of Auxiliary members on how to interview physicians on various health matters and get the interviews on their local radio stations.

Over 90 participants from 25 local auxiliary chapters took part in the one-day workshop. Following an initial briefing session of the do's and don'ts of interviewing physicians, Auxilians in small groups of eight to 10 proceeded to interview nine guest MAG physician-members.

Physicians included: H. Hilt Hammett, Jr., M.D., MAG President from LaGrange; John D. Watson, Jr., M.D., Columbus; Hoke Wammock, M.D., LaGrange; Edgar Woody, Jr., M.D., Atlanta; Jack A. Raines, M.D., Columbus; Brit Gay, Jr., M.D., Atlanta; David L. Morgan, M.D., Atlanta; Kenneth L. Goldman, M.D., Columbus; and Robert M. Patton, M.D. Columbus.

The interview sessions were patterned after an MAG-sponsored weekly 5-minute physician interview program broadcast over the Georgia Network to over 100 stations across the state (''For Good Health''). The MAG program will continue through October of 1980, and at that time will conclude a 3-year run. As a result of the Auxiliary workshop, it is hoped that participating auxiliary members will meet with their respective county medical societies to initiate contacts with the radio media in their respective areas. The physician interview programs which discuss common health problems in laymen's terms are another of MAG's projects to reach out to the community.

Over 100 suggested health care program topics with interview questions are available from the Burroughs-Wellcome Company or through the MAG. The program topics are provided by the Medical Division of the Burroughs-Wellcome Company as a communications service to medical and media professionals.

According to Auxiliary president, Mrs. Milton B. (Ann) Satcher, attendance at the June Board meeting and



(L) Evelyn Gay (Mrs. Brit, Jr.), of Atlanta, editor of *Pulseline*, the Auxiliary's official publication, and Sandee Carter (Mrs. Robert), President of the Auxiliary to the Georgia Medical Society in Savannah, listen as Mr. Reynolds relates specific ways the Auxiliary can work with doctors to improve our public relations with local communities.



Mrs. Linda Harrison from Marietta practices her newly-learned interviewing skills with Dr. Jack Raines (Columbus) as she asks him various questions about psychiatry.



Dr. John D. Watson, Jr., of Columbus, is interviewed by another active Auxiliary member as Mrs. Ann Rollins, President of the North Carolina Auxiliary, looks on.

Communications Workshop was not only the largest ever for an Auxiliary summer meeting but one of the most challenging and productive for the attendees. Mrs. Satcher says she is hopeful that within the year of her presidency, a number of local auxiliaries will be producing their own versions of the MAG radio show, "For Good Health."



(L-R) Ann Frazier (Mrs. Richard), Past-President of the North Carolina Auxiliary and AMA's Health Projects Chairman; Ann Smith (Mrs. Charles), President of the Virginia Auxiliary, L. B. Storey, MAG staff, and Ann Satcher (Mrs. Milton B.), President of the Auxiliary to the MAG.

Charles W. McDowell, Jr., M.D., Decatur, Chairman of MAG's Public Relations Committee says, "The Auxiliary can play a very important role in our public service, public education endeavors. We feel it is not only important but essential that physicians become more involved with the electronic and print media in an organized and proper way. Physicians should not be concerned about the possibility of hostile interviewers, because the interviewers will be Auxilians." Dr. McDowell called on county medical societies to cooperate with the Auxiliary chapters so that local communities can hear what local doctors have to say about those communities' common health problems. *(Reported by Ken Williams, MAG staff.)*

James F. Glenn, M.D., Duke Professor of Surgery Chosen Dean-Elect of Emory School of Medicine

James F. Glenn, M.D., a Duke University surgeon, assumed the post of dean of the Emory University School of Medicine, on August 1, 1980. The chairman of the Search Committee which selected Dr. Glenn was E. Garland Herndon, Jr., M.D., vice president for health affairs and director of Emory's Woodruff Medical Center. Dr. Herndon has served as acting dean of the medical school since the retirement of Arthur P. Richardson, M.D., on August 31, 1979. (Dr. Richardson was Emory's medical dean for 23 years.) Dr. Glenn is a national leader in the field of urologic surgery and has served as professor of urology and chief of the Division of Urologic Surgery at Duke University Medical Center and Affiliated Hospitals since 1962. He is a native of Lexington, KY.

State Heart Association Names New Officers and Board Members

Nicholas E. Davies, M.D., of Atlanta, specialist in internal medicine and cardiology, is the new president of the Georgia Affiliate of the American Heart Association. He will serve until June 30, 1981.

Dr. Davies is clinical associate professor of medicine at Emory University School of Medicine, chairman of the board of regents of the National Library of Medicine, Bethesda, MD, and past governor for Georgia for the American College of Physicians. He has been active on a number of committees of the Medical Association of Georgia and Medical Association of Atlanta.

Gus Walters, partner in Walden and Kirkland Insurance in Albany, is the new chairman of the state board of directors of the Heart Association. He is past president of the Independent Insurance Agents of Dougherty County and the Dougherty County Kiwanis Club.

Gerald F. Fletcher, M.D., of Atlanta, director of internal medicine at Georgia Baptist Medical Center, was named president-elect, and Hugh E. Hilliard, vice president for finance and treasurer of Emory University in Atlanta, is chairman-elect of the board.

(Continued on next page)

New Heart Association Officers — *continued*

Other new officers are Lois T. Ellison, M.D., of Augusta, provost and professor of medicine and surgery at the Medical College of Georgia, medical vice president; Joel Goldberg of Atlanta, chairman of the executive committee of Rich's, non-medical vice president; Mrs. Peggy Childs of Decatur, member of the Georgia House of Representatives, secretary; and Curtis H. Cadenhead, Jr. Atlanta, partner in Deloitte Haskins and Sells, treasurer

Who Smokes?

Are more people smoking than ever before?

It has been fashionable in recent years to say that no matter what the health agencies or the Surgeon General say, the number of cigarette smokers continues to increase. The fact is that since 1964, when the U. S. Surgeon General confirmed the research of the American Cancer Society (ACS) that cigarette smoking causes lung cancer and other diseases, there has been a continuing and considerable decline in the percentage of *adult* smokers in America. For example, in 1964 an absolute majority of all men 21 and over were cigarette smokers. Now the number of male smokers is down to 39%, and the same is true for men and women in most age groups.

But there is one big disturbing exception. Between 1969 and 1975, there has been an increase of half a million smokers among teenage girls. This no doubt will presage many more cases of fatal diseases among women in years to come.

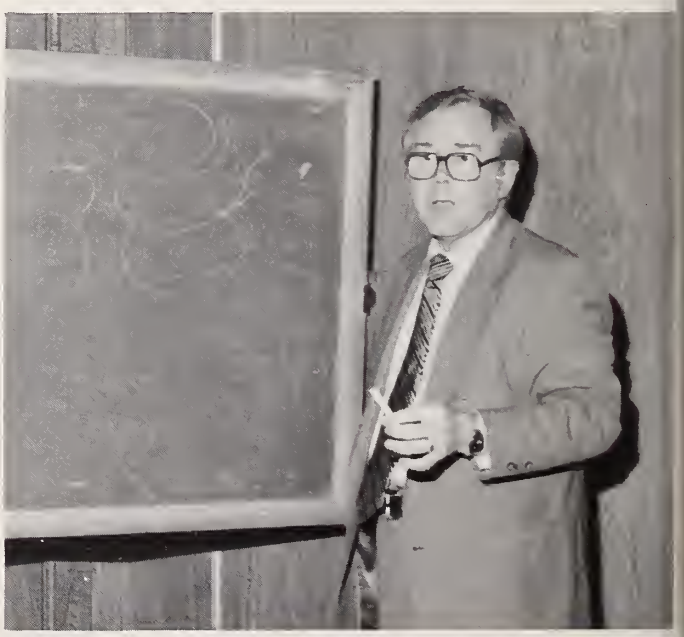
ACS studies show that one factor encouraging smoking is that many teenagers perceive the world around them as consisting of smokers. Moreover, the proliferation of seductive advertising takes unfair advantage of our children.

The ACS is introducing anti-cigarette education in earlier elementary grades. These efforts to protect the health of America's youth need and deserve the wide support of the American public.

Georgia Chapter of the American Association of Medical Assistants Holds Its Annual Meeting in Valdosta



New officers were installed at the annual meeting in April of the state chapter of the American Association of Medical Assistants in Valdosta. They are, from left to right, Dianne Frederick, CMA-A, Immediate Past President; Cecile Cate, CMA-A, Speaker of the House; Shirley Trammell, Secretary; Bonnie Landers, CMA, President-Elect; Nancy Eleam, CPS, President; Kathleen Moore, RN, CMA-AC, Vice-President; Meredith Green, CMA, Treasurer; Sandy Whitman, CMA-AC, Vice-Speaker.



Joe C. Stubbs, M.D., of Valdosta, gave a presentation on Medical/Surgical Emergencies at the 23rd annual meeting of the Georgia State Society, American Association of Medical Assistants held in Valdosta on April 17-20, 1980. A total of 123 persons attended the meeting and were instructed on various technical, clinical, and administrative subjects.

Medical Malpractice Insurers Need to Cooperate

Medical malpractice insurance companies, whether commercial insurers or physicians' mutuals, have a common purpose to "mitigate third party medical liability losses," according to Tom H. Swain, executive vice president of St. Paul Fire and Marine Insurance Company. He was the keynote speaker of the annual educational membership meeting of the Physicians Insurers Association of America (PIAA), held June 5-7 in Kansas City.

The PIAA is made up of 23 physician-owned professional liability insurance companies. These doctor-mutual insurers sprang up in the mid-1970s as one response to the medical malpractice crisis. In many states these firms compete with commercial insurance companies for medical malpractice insurance business.

"The fact that our organizations have more in common than they have in uncommon certainly is not earth-shattering — but it is often overshadowed," Swain said. "First of all, we are both here to stay. Second, we are no more — and no less — than healthy competitors. And third, we have much to offer one another and much to learn from each other." Swain listed loss prevention, informed consent, and tort reform as areas of common interest.

"Today The St. Paul writes about $78 million in physicians and surgeons liability insurance and insures close to 45,000 doctors, up from the low of 36,000 in 1975 following the market shake-out." Swain also pointed out that the reaction to The St. Paul's decision to remain in the medical malpractice market has changed over time. "When others left the market, we stayed and were applauded. As a result of the departure of other insurers, in some states we were left as virtually the only writer," he recounted. "That fact in and of itself makes the formation of some physicians mutuals a natural outcome. Over time, our image in some quarters switched from the 'stick-with-it-hero' to the 'monopolist.' And, I acknowledge when you end up as the only market, it is understandable some would regard you in that light. The absence of competition invites suspicion."

Swain told the PIAA members that The St. Paul has not opposed or resisted the formation of mutuals to fill a market vacuum. "You've hired good people. We know, some of them were ours," he commented.

In looking to the future, Swain pointed out that observers of the medical malpractice scene forecast new impending problems for malpractice insurers. He said that medical liability insurance is "like a roller coaster, and right now we could be on the verge of one of the downhill runs. At The St. Paul, our recent medical loss experience is disappointing. We've had four consecutive quarters with a combined ratio significantly over 100. During a downswing in the underwriting cycle, it becomes increasingly difficult to keep our sights trained on a major goal — to reduce the frequency and severity of medical claims," said Swain.

"To be blunt about it," he said, "the problem really is that too many medical mistakes are made. That sounds too simple, but then many problems are simple. It's the solutions that are difficult. And the solutions to this particular problem require concentrated, innovative, and long-term efforts. We're individually capable of such efforts, but together we could make even greater gains toward mitigating liability losses. Some of the areas we might consider are loss prevention, informed consent, and tort reform. The St. Paul thinks loss prevention is key, and we believe we have the essence of a good loss prevention program."

He detailed some of the loss prevention projects already underway by The St. Paul as well as new programs being started. He specifically cited the company's "Malpractice Digest," published since 1974; a liability workshop pioneered by The St. Paul in Georgia; an occurrence screening project now underway; and research projects designed to identify loss causes.

Swain said that The St. Paul is examining a number of programs aimed at improving informed consent and invited the PIAA to consider participation.

In the area of tort reform, Swain said, "Many who might have felt they made some gains on tort reform by working within the civil justice system now feel they've been sent back to ground zero as a result of recent judicial decisions. The frustration level is high among many who have to work with the system with any regularity. They think our present tort system is abused and overused. Yet many efforts to reform eventually fail, usually because tort relief is legislated exclusively to the benefit of health care providers thereby discriminating against other personal injury tort professionals.

Swain pointed out that The St. Paul has provided support to the Rand Corporation's Institute for Civil Justice which will thoroughly and objectively study our justice system and its impact on society.

MEDICAL MEETING CALENDAR

AUGUST

20—*Atlanta;* **Managing People and Money in Your Practice;** AMA faculty; Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (Toll Free in Georgia).

20—*Atlanta;* **Medical Collection Management Workshop** (for medical assistants and office personnel); AMA faculty; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (Toll Free in Georgia).

21—*Macon;* **Managing People and Money in Your Practice;** AMA faculty; Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (Toll Free in Georgia).

21—*Macon;* **Medical Collection Management Workshop** (for medical assistants and office personnel); AMA faculty; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (Toll Free in Georgia).

21-22—*Birmingham, AL;* **Seminar on Quality Assurance;** Category 1 credit; Contact: Jim Hulett, Alabama Hospital Association, Box 17059, East Station, Montgomery, AL 36117. PH: 205/272-8781.

22-23—*Lake Buena Vista, FL;* **EKG Interpretation and Arrhythmia Management;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800-525-8646.

22-24—*Hilton Head, SC;* **Clinical Management of Coronary Disease and Exercise Testing;** Category 1 credit; Contact: Director of CME, Dept. 4, International Med. Ed. Corp., 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

SEPTEMBER

18-20—*Sea Island;* **Annual Meeting, Georgia Surgical Society;** Category 1 credit; Contact: William C. McGarity, MD, Secy.-Treas., Georgia Surgical Society, 1365 Clifton Rd., NE, Atlanta 30322.

26-27—*Las Vegas, NV;* **EKG Interpretation and Arrhythmia Management;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

26-27—*Atlanta;* **Annual Meeting and Scientific Sessions, American Heart Association, Georgia Affiliate;** Category 1 credit; Contact: Ann Angelo, American Heart Association, Georgia Affiliate, 2581 Piedmont Rd., NE, Broadview Plaza, Level "C," Atlanta 30324. PH: 404/261-2260.

27-30—*Kansas City, MO;* **Clinical Drug Therapies (AMA);** Category 1 credit; Contact: Frank Chappell, AMA. PH: 312/751-6606 (Office) or 312/644-2426 (Home).

OCTOBER

3-5—*Callaway Gardens;* **10th Annual Meeting Georgia Gastroenterologic Society;** Contact Harold Asher, M.D., Secty-Treas., 340 Boulevard, NE, Atlanta, GA 30312, and 2nd Annual Meeting Georgia Society for Gastrointestinal Endoscopy; Contact W. Scott Brooks, M.D., 1365 Clifton Rd., NE, Atlanta, GA 30322.

4-5—*Big Canoe;* **Closing Your Practice;** AMA faculty; Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (Toll Free in Georgia).

6-9—*New Orleans, LA;* **32nd Annual AAFP Scientific Assembly** (World Meeting for Family Physicians); Category 1 credit; Contact: Camille Day, Executive Director, Georgia Academy of Family Physicians, 11 Corporate Square, Suite 205, Atlanta 30329. PH: 404/321-7445.

9-10—*Atlanta;* **The Pain-Disabled Patient;** Contact: Ronald G. Havican, Center for Rehabilitation Medicine, Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5507.

10—*Atlanta;* **Eighth Annual Cardiac Symposium;** Contact: Gerald F. Fletcher, MD, Dir. of Internal Medicine, Georgia Baptist Hospital, 300 Boulevard, NE, Atlanta 30312. PH: 404/659-4211.

13-14—*Chattanooga, TN;* **Tennessee Valley Medical Assembly;** Contact: F. M. Richardson, Suite 313, 960 E Third St., Chattanooga, TN 37403.

19-24—*Atlanta;* **66th Annual Clinical Congress of the American College of Surgeons;** Category 1 credit; Contact: Dianne Currie O'Rourke, Mgr. of Public Information, American College of Surgeons, 55 East Erie St., Chicago, IL 60611. PH: 312/644-4050, ext. 324.

24-26—*Atlanta;* **Clinical Management of Coronary Disease and Exercise Testing;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800-525-8646.

26-30—*Boston, MA;* **46th Annual Scientific Assembly of the American College of Chest Physicians;** Category 1 credit; Contact: American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

NOVEMBER

6-8—*Atlanta;* **32nd Annual Georgia Academy of Family Physicians Scientific Meeting;** Category 1 credit; Contact: Camille Day, Executive Director, GAFP, 11 Corporate Square, Suite 205, Atlanta 30309. PH: 404/321-7445.

14-16—*Sea Island;* **Primary Care of Hand Injuries;** Contact: American Society for Surgery of the Hand, 2600 South Parker Rd., Suite 132, Aurora, CO 80014. PH: 303/755-4588.

15-16—*Albany;* **1980 Georgia Association of Emergency Medical Services Conference;** Contact: C. B. Gillespie, MD, Course Dir., 810 14th Ave., Albany 31701. PH: 912/435-1458.

16-19—*San Antonio, TX;* **Southern Medical Association's 74th Annual Scientific Assembly;** Contact: Southern Medical Association, 2601 Highland Ave., Birmingham, AL 35205. PH: 205-323-4400.

16-21—*Dallas, TX;* **RSNA 66th Scientific Assembly and Annual Meeting;** Contact: Radiological Society of North America, 1415 West 22nd St., Suite 1150, Oak Brook, IL 60521. PH: 312/920-2680.

21-23—*Atlanta;* **1980 MAG Scientific Assembly;** Category 1 credit: Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (Toll Free in Georgia).

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



WHEN ANXIETY AND TENSION MAGNIFY PAIN IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® C IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor trenquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised thet if they become pregnant during therepy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placentel barrier. it is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobemate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk es compered to maternel plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101

TM

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® (IV)

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Wernings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antegonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Senal hepatic enzyme determinations are also recommended

Copyright © 1980, Wyeth Laboratones
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa. 19101

JOURNAL
of the medical association of
georgia

Medicine: It's a Beautiful Story

HOYT D. GARDNER, M.D., *Louisville, KY**

Mr. President, distinguished leadership at the rostrum, colleagues, and ladies and gentlemen, it is a great pleasure and privilege for Rose and me to be with you — and to return here again — particularly in my present capacity. Your state and your leadership had no small amount to do with the fact that I am here as President of the American Medical Association.

Your delegation to the American Medical Association has demonstrated through the years what it can do, even though it comes from a small state, and I'm particularly grateful to them for being the beneficiary of this strength. I speak particularly of your delegation of Dick Flood, Jack Leckie, Harry Weeks and my confidant and mentor, who in all kinds of cataclysmic situations has stood fast with strong support, Frank Holroyd, who is my manager. Thank you.

It is a great pleasure to bring you greetings from the Association — the American Medical Association — and, of course, from Kentucky. Kentucky is a state, as you are aware, from the motherhood of Virginia. Furthermore, as you well know (I think I've told you this before, but I want to emphasize it again because Carl Cooper and I are well aware of these things), Kentucky is a state that provides all the basic essentials of life — tobacco, whiskey, and race horses. Having been here yesterday and at noon today, I certainly want to express to you all for the strong support you're giving us. These commodities are extraordinarily essential to us because from them come our basic monies which we, in turn, spend on women and politics. That, of course, explains our perpetual state of poverty.

I thought we would visit together today for a few minutes about our Association, the American Medical Association. If you're a physician, it is your Association, whether you hold membership or not.

I wish also to express concern for the fact that the beautiful, magic story of medicine is left untold, not by the outside world so much, but by ourselves, because of the pressures of the things we do daily in life.

The miracles, we create unthinkingly. Because of the great things that they are, we take it for granted because we do them routinely, and have been taught to do so. The professionalism, which is exemplified by each of you personally in your office and in your hospital and in your Association, is taken for granted as much as we take oxygen for granted in the air. So as a consequence, the real story of what our Association represents; what medicine represents; what the profession represents; what doctors are known for, goes untold — particularly because we ourselves, in all this great haste to do these things, don't tell it.

Tell the Story

Sometimes this is because of modesty, or because what we have to do consumes so much of our time. But, most of all, because it is so great, so good and so magic, it is taken so much for granted that it goes unsung. So I thought maybe today, for these few minutes, we would visit together. May I urge you to take this story back and begin to tell it, using the few seconds you can find each day to extol the virtues and the magnificence of these things about your profession that are provided to our people.

We can visit together a little bit about medicine in this country today. We can talk about your Association, the American Medical Association. Then I want to talk to you about a specific piece of legislation and then leave you with a thought for the future.

* Dr. Gardner is President, American Medical Association. This article was presented at the first session of the House of Delegates, 112th Annual Meeting of the West Virginia State Medical Association on August 22, 1979. Reprinted from the *West Virginia Medical Journal*.

I'll start our discussion and visitation together by assuring you at the outset, as I will prove to you conclusively and as you already know, your Association has not been waiting on a train.

Let's look at the profession in this country today — 407,000 physicians are licensed and alive in this country today and 87,000 of those are colleagues who have joined us from foreign shores. Last year, there were 19 million operations in our hospitals, and 34 million hospital admissions. Three million people visited our offices every day, resulting in nine million prescriptions daily. We have 124 accredited medical schools in this country, and — setting an all-time record — they then graduated last year over 16,000 students. Sixty-four thousand students are enrolled for this next year, also an all-time record in the history of medicine in this country and in the world.

There are 40,000 doctors this coming year involved in postgraduate medical education. Again, this is an all-time record. Think of this — there are 200,000 ongoing research projects in this country right now, *200,000*. From research this last year have come 5,000 new descriptions of appliances, techniques, drugs, and other procedures, and 1,000 newly described surgical procedures. Once more, these are all-time records that are being set in *this* country and all are a result of motivation to excel — to exceed — to benefit.

Our profession is represented today by 51 specialties. Think of this. An all-time record. No other country has this kind of exemplification of expertise and technology. When I started practice 20 years ago, there were 23 specialties, and now we have developed ourselves to the point where we have more than doubled this in two decades.

Want Complete Change

Think also of this. All this amalgamation of what we do has resulted in a gross national product of 180 billion dollars last year, making us the second or third largest industry in this country. And I signal this to you because think what happens when government tinkers slightly with agriculture, steel, motors, or energy. And yet you hear demagogues say that they want to completely change the system. Change the approach. Change the whole procedure, and they say it continuously.

Let's look, then, at our organization for a moment. Under the broad canopy of the American Medical Association, there are 2,300 organized facets — from the county to the state, to the specialty, to the subspecialty — all these put together voluntarily by doctors who want to exchange, to visit, to excel, to have the opportunity of interprofessionalism that the organization makes possible, as well as also to maintain the standards of professionalism in what we do. And outside of the umbrella of the American Medical Association — your Association — there are 283 other organized facets. As a matter of fact, after hearing all this, one is indeed stunned when someone says that there is no system of medicine in this country. Actually there are almost 2,500 organized facets of such a system.

Let's talk further about the AMA for a moment, and share some of our virtues. As you know, the AMA is located at 535 North Dearborn Street in Chicago. It is incorporated under the laws of Illinois to make it possible for us to do business. The AMA is 139 years old with 215,000 dues-paying members last year. There have been 134 presidents, and with complete modesty, I tell you that eight of them have come from Kentucky. This ties us with Pennsylvania and California as one of the three states with the most past presidents of the American Medical Association. If things work out, and we can get Frank Holroyd to manage us, we're going to have nine, and Pennsylvania and California will be in second place.

The past year, we saw all-time record numbers in the House of Delegates — 274 members. And from this House of Delegates, whose members are elected from the state and county levels, come the only policy that the American Medical Association has. It stands as a complete exemplification of grass-roots support.

Best Example of Democracy

Three years ago, we studied the sources of resolutions that went before the House — the voice of medicine, which is the House of Delegates — and became policy. Almost half of them came from individual doctors in county societies who had ideas they thought were worthwhile. They submitted their ideas to the judgment of colleagues at the county level, and those colleagues thought those ideas were important. Subsequently, the ideas were submitted to state societies, and those societies thought they were important. Then, the resolutions were submitted to the AMA House of Delegates. The House thought they were important, and those ideas became the policy of medicine in this country — originating, remember, from individuals. This is repetitive, and it happens almost every time that the House meets — almost half of our considerations come from those who have felt deeply and strongly that certain things should become the policy of the House. There is no better example of democracy in the world than your Association.

Between the two sessions of the House each year there are others held by the Board of Trustees. Twelve Board members are elected by the House of Delegates, and Bill Hotchiss of Virginia is one of those. The President, President-Elect, and Immedi-

ate Past-President complete the 15 members. We have 950 employees in Chicago. Last year, we had a gross budget of $64 million. All of our activity is administered by our Executive Vice-President, Jim Sammons.

Let me point out a very positive story for you. Eighty-five per cent of that budget last year was spent on the enhancement of the profession or the betterment of people's health. Sixty-one per cent of it was spent on pure science of medicine. There is no other major organization in this country, and I'm sure abroad, that spends, for things outside its own structure, this proportion of its budget. Again, of the 64 million dollars, 85 per cent went beyond ourselves to improve our citizenry, to improve the profession, to extol and interchange ideas, professionalism, technology.

Think also of this. The AMA is the largest publisher of scientific material in the world — 26 major publications, a weekly newspaper, a monthly journal, with 38 million copies distributed last year and now being distributed overseas in the Far East, South America, England, and now China. One billion people are asking for this expertise and technology. And, by the way, through the World Medical Association, we maintain ongoing relationships with 141 other countries. There is a continual parade of people going through our corridors at 535 North Dearborn that say: "Give us this help, give us this expertise, give us this technology. You exude it. You have it more than anybody else. Send it to us." As I say, the most recent example is China. And I repeat, a billion people now are asking for new, modern medicine. Who are they asking? Us. The AMA. Medicine in this country, and your organization.

Physicians on AMA Computers

Every licensed physician in this country is known to the AMA computers, the only organization that has that information. By the way, the computers in the AMA are the equivalent of those in HEW, and I hope that will give you some feeling of reconciliation and assuagement. As you recall, not too long ago, there was a release from HEW in Washington, a statement of the number of physicians who had received in excess of $100,000 from Medicare. This created an implication, at least, that there was something illegal about this. After we submitted the material to our computers, we found 64 per-cent error in the HEW listings. This has been called in some channels "computer malpractice." Since HEW found out that we did channel information through our computers, you will note that it has not come out with this kind of information since. If it does, I assure you we will submit it to our computers again. Not that we don't trust HEW. We simply like to verify its releases.

This fits in with experiences I guess all of us have had. Often, usually when I'm leaving my car to run in the hospital, somebody will walk up and say, "By the way, I've got about 5 minutes, tell me what the AMA is doing." I ask him what 2 weeks he would like to take off, and go with me to Chicago or West Virginia. So far no one has accepted my offer, so I'm not sure how serious their questions are, but I cannot answer a question like that in 5 minutes in a parking lot.

Now let me talk to you about something else, because the idea is to "tell me today what the AMA is doing for me now." It is easy to do. The AMA gives you your professionalism. It sets you apart as being different. As a matter of fact, it gives you the creditability that allows you to be licensed and allows you to maintain your practice. It makes you different from the ditchdigger, makes you different from the salesman; it makes you different from the farmer; it makes you different from anybody else. Because you are so certified by the American Medical Association, and always have been. You are the professional. You are the doctor. Your credentials are correct.

Why do I say this? Because the American Medical Association, either singly or jointly, accredits all the medical schools, all the hospitals, all the ancillary health care facilities, all the ambulatory health care facilities and the medical schools here and in Canada — I bet you didn't know that. And all of this is done voluntarily. Nobody mandates that this has to be done. This is the most regulated medical profession in the world — in this country. The most regulated right now, and 80 per cent of it has been done by the profession itself — 80 per cent of it. Why do I say that? Tissue committees, peer review, medical audits — all of this is done voluntarily by physicians to insure that the quality of care is correct. And, it's done voluntarily. And, if it were not done by us, think of the alternative. Because it has to be done, it would be done. It would be legislatively done.

Never Debate About Quality

But nobody, you see, in the debate and dialogue that goes on challenges the professionalism of you. The debate is about cost, and sometimes it's about regulations; but, it is never about quality. It is never about the fact that we do certify all of these things, because it's done by whom? By you — your Association — the thing that gives you your professionalism, your professional life. It "births" you, it continues you and it will follow you unto death, because you always will be John Jones, M.D., so certified, so accredited, so professionalized by your Association — the American Medical Association.

Now I want to talk about a couple of areas which do have some connotation of controversy about

them. It is important that you understand these things, because they are things the profession does for you every day. They lie in the legislative and the political arena.

What about the Washington Office? What does it do? What's it about? As I told you, we had last year a gross budget of $64 million. One million, three hundred thousand dollars has been budgeted for our Washington Office, about one per cent or less, for legislative matters.

There are 30 employees in the Washington Office, five of them lobbyists. You've heard references to that giant, highly-financed lobby of the American Medical Association obstructing health care for people. You've heard the demagogues say this time after time. I say, if five lobbyists is a giant lobby, God help us for a diminutive lobby. If one half of a per cent of somebody's budget is a high-finance program, Lord save us there, because the lobby that goes on within the Congress and with bureaucracy itself would eat us tomorrow.

But let me give you an example of how good our people are for us — for you. These five lobbyists last year, and let's look at the 95th Congress — we're in the middle of the first session of the 96th now, standing in adjournment until next month. Ten thousand bills came before the 95th Congress. Think of this, 2,500 of them had direct medical connotation — one fourth, one fourth of the federal legislative consideration had to do with health care. You would indeed have to be a cave-dweller to say that you have no time for legislation and politics, when 25 per cent of the considerations of federal legislation has to do with you.

760 Legislative Efforts

From this office in Washington came 760 different efforts related to legislation in that Congress, either in testimony or research — all kinds of efforts in getting people together. By the way, our testimony today is given by the best expert we can find in the field when they ask for it. And, they're asking all the time. There is a continuous stream of witnesses. But neither the President nor the Chairman of the AMA Board goes down there any more and reads a long, drawn-out statement. We find the best expert there is in the area, and we ask him to give the AMA testimony. You'll note in the last 2 or 3 years there hasn't been so much criticism. I can give you an example of this, which occurred not very many months ago, before one of our Senate committees.

A senator was interrogating a gentleman physician, a scientist, who was giving testimony. He said, "Well doctor, I'm reading here from a document," and he went through enumeration of various and sundry things, and in a rather skeptical tone, he said, "I would like to get your reaction to this expert's opinion." The physician said, "I will be glad to give them to you, sir, I wrote the article." It was interesting to see that the senator immediately withdrew from the field, and remained silent thereafter.

This is an example of what we are trying to do in the name of modernization of your Association — to give the best that we can, every time that we can. I'll tell you, you do get a funny feeling when you work with some demagogue for 3 months, getting together a preventive medicine program for which Washington assembled internationally known people — a program with national exposure, and several millions of people watching it onTV — and then realize that most of that effort was put together at AMA expense, from your dues. Most of the program to which I'm making reference was put together by our staff jointly presided over by our immediate Past-President, Tom Nesbitt. But then we find that a senator who resides somewhat above New York and slightly below Maine gets on TV one week later and says that the obstructionism of medicine and the AMA, which cares nothing for preventive medicine, must be brought to task. That 3-month program was on preventive medicine. We co-chaired it with the senator, and most of it was developed by our staff and at our expense. Now that's demagoguery really in the highest degree, and it's politicizing an issue only for personal aggrandizement. It is not in your best interest, nor in the interest of others, when we have that kind of people in high office who are giving that kind of representation of facts.

Testimony Positive

There is another thing that you need to know. In all of this testimony that we give, 90 per cent of it is positive. Ninety per cent of what we say, we insist, yes, we should do this. Yes, we should do this for the Armed Forces. Yes, the nurses should be helped. Yes, the medical schools should have capitation. Yes, these research funds should be provided. There is a continual parade of "yesses." But you often hear about the negativism of the image of the AMA. So do this the next time it comes up. Say, all right, take national health insurance out of it, and tell us now what you think of the AMA. Leave national health insurance to the side, and tell us how you react to the AMA now, and see if, first of all, they know anything, and if they do, if they know anything negative.

By the way, our position on national health insurance has been positive. For several years, beginning in 1971, we had our own bill in. Last year, the House again decided our policy should be to fill in the gaps because 90 per cent of our people do have major medical, and 75 per cent of them have catastrophic. Only 10 per cent of our people, for whatever reason, are medically disenfranchised. Do we completely

destroy all this marvelous, glorious thing that's going on in the name of 10 per cent?

But we've had a positive position. We're talking about filling in the gaps. By the way, you talk about 10 per cent of medically disenfranchisement. It's 18 per cent in England, and they have had 30 years of government effort to correct it. Russia has admitted — notice I say, admitted, to 15 percent medical disenfranchisement, yet they have total control. And yet here, people voluntarily motivated to excel only have 10 per cent? Which leads me to the national health insurance situation. I told you I want to speak specifically about this because when you ask people to leave national health out of it, they have no other real things to talk about the AMA outside of the profession. But the next time it comes up, say, all right, we will go. We will admit and accept and accede to your ideas of national health insurance if it will fit into certain patterns. We will accept it, if you can say yes to any of the following questions:

Will there be less regimentation? Will there be less bureaucracy? Will there be better management? Will it be more private and personal? Will there be less cost? Will there be less politics? Will there be more personal motivation and selectivity by patient and doctor? Will there be more compassion and feeling for the sick and for the ill? And lastly, if the answer is yes to any of these questions, where is the example? Where is the example?

Learned Professions Called Upon

No other place in the world has the kind of health care this nation enjoys, and you have only to travel any place to find it out. But new challenges are ahead, and they are approaching us rapidly. We must deal with them. Since the beginning, the four original learned professions — medicine, law, religion, and education — have been called upon by human kind for advice and consent, counselling, a sense of direction as to what civilization should do when it is confronted with basic decisions. The four original learned professions always have been the tutors when people must make decisions and set priorities. Everyone knows today that this is a rapidly-shrinking world. There isn't an abundance of many resources any more, and resources we have are rapidly being utilized. As a consequence, civilization again is turning to the four original learned professions of medicine, law, religion, and education for a sense of direction.

You ask, "What are you talking about?" I speak specifically of examples such as this: amniocentesis, test-tubing, and cloning. You say, ah, cloning. What's that? Tadpoles. But colleagues and friends, you know the expertise and the technology of our profession. When you're talking about a tadpole today, you're talking about a 500-pound frog tomorrow. It's here! Everything starts with a tadpole. The majesty of this profession will lift it up, the 500-pound frog on the finger and twirl it around and say, I told you so.

What else am I talking about? Karen Ann Quinlan is an example. Quality of life is gone, but the body goes on, through your expertise, your technology, and your abilities to sustain the body. Go through the geriatric centers. The same thing is happening, but at the cost equivalent to sending seven or eight kids to college every year. Civilization is deciding what to do in these situations.

Owe AMA Strength to Continue

Let's take another complete example. Here people are committed and absolutely believe emotionally with everything within them in their moralities and their thoughts about an issue that's been raging in this country and around the world — abortions. What about abortions? People are returning to the four original learned professions for decisions. Which leads me to a major point that I want to emphasize to you about your Association — the American Medical Association — and the 141 countries around the world that turn to us for a sense of direction. Nobody can speak for the original learned profession of medicine in this country and in this world today except the AMA. Your Association, the Association that gave birth to you, that continues you and will be with you in the hereafter. If there is a challenge that rests on your shoulders, it is at least this much. You must give your organization the strength to continue to speak and give a sense of direction. Yes, indeed, to civilization, if you owe it nothing else, you owe the strength of organizational membership.

One of our critical issues today is membership. If you feel any sense of responsibility whatsoever, not only for your profession, but for civilization itself, you owe your Association, which will give the guidance to civilization that is demanding it, at least your membership. For all it's done for you, and to what we owe to all future generations, you need to show appreciation and recognition.

So, I leave you with this thought. On the looming horizon that's coming at us so rapidly, tell the beautiful story that you can tell of all the magic you perform every day. Give your Association at least the strength of membership for all that it has done for you, but most of all, for what it has done and will do for so many forever.

An overview of a new therapeutic adjunct.

Biofeedback Therapy in Clinical Practice

STANLEY L. CHAPMAN, PH.D., and V. R. RAO, M.D., *Atlanta**

"BIOFEEDBACK" represents exactly what the word itself implies — "feedback" or information about a biologic process. Its significance lies in the importance of information for learning.

It is hard to imagine learning any skill without receiving information from the environment. For example, when a person is learning to ride a bicycle, he receives information back dependent on the behavior of the bicycle. He easily can detect the effects of his motor activities by feeling whether the bicycle becomes wobbly and by seeing whether it moves in the desired path. In a normally-functioning person, this naturally obtained feed-back, combined with some instruction and observation of others, is sufficient to learn the skill adequately. But if the person does not have a properly-functioning central nervous system and is unable to feel this wobbliness or see where the bicycle goes, he might need to rely on some other form of information. If he were capable of hearing normally, for example, he might learn to ride if a device were attached to the wheel which sounded a tone every time the wheel deviated from a straight path. This hypothetical system exemplifies a major use of biofeedback — to help a person use a part of his central nervous system which is capable of processing information to compensate for a dysfunction. The Braille system which uses the sensation of touch to teach blind persons to read is a perfect example of this principle in daily use.

An important use of biofeedback is to bring bodily functions into awareness and control. Awareness about a function comes from a measurement of input from the system and a representation of that input in a form the individual easily can detect, usually a visual or auditory stimulus. For example, teaching muscle relaxation can be aided by a biofeedback device which transduces the electrical signals from muscles into a tone which changes pitch or frequency with changing tension or into readings along a meter or digital display. To benefit from this feedback, the individual must have the capacity to learn two skills: discrimination and control. Discrimination, or information about a target function, initially is provided by the biofeedback device, but the person must associate the readings from this device with his own internal perceptions so that he can learn to perceive it on his own. The trainee then must use biofeedback to learn to modify his thoughts, emotions, or behaviors in such a way so that he can maintain these functions under control not only in the laboratory, but also whenever necessary in daily living. This transfer of training may require carefully-programmed shaping of responses, home practice, and environmental planning, as well as sustained motivation.

The proper use of biofeedback must follow a thorough medical and/or psychologic evaluation. Such an evaluation should determine whether the person's problem is related specifically to the parameter measured by a biofeedback device. Because the underlying physiology of many disorders is not well understood, this determination can be quite difficult. For example, one might encounter atypical facial pains accompanied by high levels of muscle tension in some facial muscles and remain unsure about whether the tension is causing the pain, the pain is causing the tension, or the two processes are interacting with each other or with a third process.

The individual's motivation and capability for learning also need to be assessed carefully. The issue

* Drs. Chapman and Rao are from the Department of Rehabilitation Medicine, Emory University, 1441 Clifton Rd., NE, Atlanta, GA 30322.

of capability is critical in patients such as stroke victims who have central nervous system impairments. Motivational issues often need to be considered in individuals whose physical or emotional problems may be providing them with financial or social benefits or meeting intrapsychic needs.

A final consideration involves the likely benefits, costs, and risks of biofeedback training in comparison with the best available alternative treatments. Though failure with any treatment can be harmful emotionally, biofeedback generally does not carry the major risks of side effects and potential physical harm embedded in many other medical treatments. Moreover, in many cases, such as severe muscle contraction headaches, biofeedback training may be likely to cost less and result in more significant pain relief than continual use of pain medications. In other cases such as cluster headaches, appropriate medication appears more likely to yield a positive result. When used properly, biofeedback is rarely the sole treatment modality employed, but is part of an overall treatment regimen. It becomes a much more effective tool for relaxation training, for example, when combined with instruction in techniques of deep muscle relaxation and in stress management skills than when used alone.

Clinical Uses

Any physiologic measure relevant to an individual's medical problem and capable of being altered can be used in biofeedback training. It is impossible in a short paper to list adequately the many medical conditions in which biofeedback has been used effectively. Success has been reported using different types of biofeedback for conditions as diverse as epilepsy, diabetes, reflux esophagitis, and temporomandibular joint disease.[1]

Disorders involving striated, smooth, and cardiac muscles have been definite clinical applications for biofeedback training. Electromyographic (EMG) biofeedback for the purpose of teaching relaxation of muscles has been used extensively, because sustained muscular contraction is an important etiological factor in a myriad of medical dysfunctions. Budzynski, Stoyva, Adler, and Mullaney[2] performed a classic study in 1973 which demonstrated almost complete relief of muscle contraction headaches and greatly reduced medication intake for up to 18 months post treatment as a result of EMG biofeedback for the muscles of the scalp and neck. A group receiving sham EMG biofeedback and a no-treatment control group showed little change in headache activity. Though the closeness of the relationship between EMG activity and headache activity as reported by the patient has been ambiguous, subsequent researchers have been consistent in reporting significant improvement in headache symptomatology with relaxation training assisted by EMG biofeedback for follow-up periods as long as 5 years post treatment.[3] Results using EMG biofeedback for muscle pains in areas other than headaches have not been as consistent, perhaps partly as a result of the lack of diagnostic clarity in the experimental groups.

Many other forms of feedback besides EMG have been used for the purposes of general relaxation, such as measures of heart rate, blood pressure, temperature, vasodilation of arteries, EEG, and GSR. People express anxiety in different and highly specific ways, and it is important for the clinician to assess a person's psychophysiologic profile by measuring multiple functions and determining how they vary in several stressful and nonstressful situations. Many clinicians have assumed erroneously that EMG measurement from the frontalis muscle yields a good indication of overall relaxation, but it is not necessarily correlated with other measures.

Thermal biofeedback also has been used widely for the purposes of relaxation training. This simple form of feedback involves placing a temperature-sensitive probe on a finger or hand and instructing the subject to increase the temperature. The effectiveness of thermal biofeedback appears to lie in the correlation between peripheral dilatation and a lowering of sympathetic nervous system arousal. Autogenic training, which involves repetitive suggestions of warmth and heaviness, is usually paired with the feedback. Thermal biofeedback and autogenic training have been used widely and with considerable success in stress-related migraine headaches,[4] though some researchers[5] have found equal effectiveness with sham thermal biofeedback, suggesting the importance of the autogenic training or of nonspecific factors. Success also has been reported for the use of thermal biofeedback in Raynaud's phenomenon,[6] in which vasoconstriction has become a chronic pain-producing condition.

Biofeedback has been used not only for the purpose of alleviating stress-related disorders, but also for "neuromuscular re-education," or the teaching of better muscular control in individuals with neurologic disorders. The goals of neuromuscular re-education are to increase EMG activity in weak or paretic muscles and to reduce the activity of spastic muscles. Basmajian[7] pioneered work in this field with his findings that individuals can learn to control single motor units activated by a single motorneuron in the spinal cord through EMG biofeedback. This discovery caused clinicians to appreciate the individual's potential for developing highly specific control of muscles by altering cortical activity.

To teach increases in muscle activity, the patient is made aware of minute or overexaggerated muscle contractions through visual and auditory feedback from that muscle. Sometimes aids are used to help

initiate activity in a muscle, such as massage or pushing to induce tension, or weak electric shocks.[8] The successful patient gradually learns to produce the cortical activity associated with the increased muscle activity and becomes more and more dependent on the visual input from the moving limb segment and less and less dependent on the auditory and visual cues generated from the biofeedback device. EMG biofeedback to increase muscle activity or reduce spasticity has been found to be beneficial in aiding the rehabilitation of patients with muscle problems associated with such disorders as hemiplegia, dystonia, stroke, spinal cord injury, cerebral palsy, and spasmodic torticollis, to name just a few.[1, 8]

In summary, biofeedback training is a fairly recently developed treatment modality with proven clinical effectiveness for several types of medical problems, mainly those involving striated, smooth, or cardiac muscles or those with important stress components. Its potential for use in general preventive medicine and for a wide variety of other medical conditions awaits the test of careful basic and applied research. As with any new treatment modality, the risks of exploitation and quackery are high. It is worth re-emphasizing that biofeedback should only be attempted after careful medical and psychologic assessment is performed.

The critical importance of the quality of the relationship between the health practitioner and the patient in determining success with biofeedback has been demonstrated in study after study. Success depends on the patient having enough trust and positive expectation to continue to work at learning and applying new and sometimes difficult skills. Any physician who believes that successful results are to be expected from hooking a patient up to a machine and telling him to turn a tone off or on or move a meter up or down will be greatly disappointed.

At this time a clear mapping of the physiologic and psychologic processes that mediate biofeedback training is impossible. There is no question but that factors such as an increased belief in self-control, greater hope, and reduced helplessness are important components of biofeedback therapies. Of course, mysteries about modes of effective action are not unique to biofeedback, but characterize many traditional medical procedures such as drug therapies.

A major advantage of biofeedback lies in its placing much of the responsibility on the patient for his own clinical improvement. It discourages the passivity and dependency which can become characteristic of patients with serious medical problems. The idea that one can learn to exercise some self-control over a difficult problem such as chronic pain can be in itself quite therapeutic and liberating. In addition, there is a large body of clinical and experimental evidence that improvements ascribed to one's own efforts are likely to be maintained much better than those attributed to forces an individual believes are beyond his control.

References

1. Brown BB. *Stress and the Art of Biofeedback*. New York: Harper and Row, 1977.
2. Budzynski T, Stoyva J, Adler CS, Mullaney DJ. EMG biofeedback and tension headache: A controlled outcome study. Psychosom Med 1973; 35:484-496.
3. Diamond S, Medina J, Diamond-Falk J, DeVeno T. The value of biofeedback in the treatment of chronic headache: A five-year retrospective study. Headache 1979; 19:90-96.
4. Sargent JD, Green EE, Walters ED. Preliminary report on the use of autogenic feedback training in the treatment of migraine and tension headache. Psychosom Med 1973; 35:129-135.
5. Mullinix, JM, Norton BJ, Hack S, Fishman MA. Skin temperature biofeedback and migraine. Headache 1978; 18:242-244.
6. Sappington JT, Fiorito EM, Brehony KA. Biofeedback therapy in Raynaud's Disease. Biofeedback and Self-Regulation 1979; 4:155-169.
7. Basmajian JV. Learned control of single motor units. In, GE Schwartz and J Beatty (Eds.) *Biofeedback: Theory and Research*. New York: Academic Press, 1977.
8. Baker MP, Wolf SL. Biofeedback strategies in the physical therapy clinic. In JV Basmajian (Ed.) *Biofeedback: Principles and Practice for Clinicians*. Baltimore: Williams and Wilkins, 1979.



SOME MALPRACTICE INSURANCE POLICIES SETTLE FOR JUST ANYBODY.

Today, all too many people are finding it easy to sue. And unfortunately, all too many insurance companies are finding it easier on themselves to settle. Quickly and out of court. Little thought is given to defending your reputation.

In fact, your insurance company may not even give you an option to fight a claim. Or if you do have that option, you can be hit with a costly penalty for going to court.

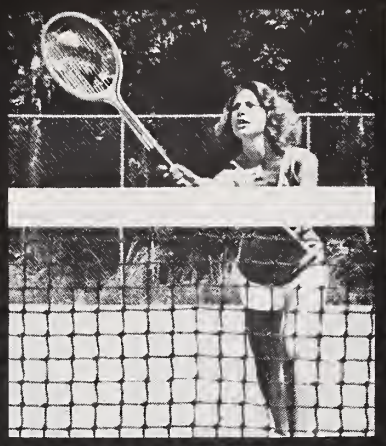
And there are other ways your insurance company may not stand behind you. For instance, chances are to save costs and time your company will use a claims adjuster to handle your case. Not a lawyer.

It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working hard for doctors. We know the strong coverage and knowledgeable service physicians need from their liability insurance. And because we specialize in this one field, we can offer a superior policy at a realistic premium. Premiums based on actual costs in your state.

Don't settle for just any insurance. Get a policy that really stands behind you. Contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas phone 1-800-231-2615.

ICA INSURANCE CORPORATION OF AMERICA

MALPRACTICE INSURANCE IS BETTER TODAY. BECAUSE OF ICA.






Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567

The history of the School of Medicine at Morehouse College is presented, with highlights of current activities and future plans.

The School of Medicine at Morehouse College:
Status in 1979 and Plans for the Future

LOUIS W. SULLIVAN, M.D., *Atlanta**

On Sept. 11, 1978, the School of Medicine at Morehouse College opened with a charter class of 24 freshmen students, becoming the first medical school to be founded in Georgia in 70 years, and the first medical program to be founded in the United States by a minority institution in the 20th Century.

Although the dream of a medical school in the Atlanta University Center had existed since the development of the educational consortium in 1929, Morehouse School of Medicine was the result of the active efforts of many individuals and organizations, public and private, over a period of 9 years.

The need for more physicians in Georgia was recognized in 1969 in the report of the Task Force for Physician Manpower to the Georgia Comprehensive Health Planning Council. Georgia ranks 36th among the states in physician manpower, and many of our counties have too few physicians or none at all. As a result of the recommendations of this task force, in 1973, Morehouse College obtained funds to carry out a study on the feasibility of developing a 2-year medical school. The ability of Morehouse College to organize and implement a 2-year curriculum in medical education was suggested by the outstanding program in pre-medical education in the college (some 7% of the black physicians in the United States received their undergraduate education at Morehouse College) and the institution's demonstrated success in its fund-raising efforts.

Funds for curriculum development were secured from the Department of Health and Human Services (DHHS — formerly DHEW) in 1974, and academic planning commenced. Recruitment of faculty and staff, planning for facilities, and development of administrative procedures followed thereafter. Consultation visits with accreditation officials were initiated in 1973 and were continued through 1976.

On June 30, 1977, following a survey team's review of the Morehouse medical program in January, 1977, a letter of reasonable assurance of accreditation (LRA) was issued by the Liaison Committee on Medical Education. The granting of the LRA was based upon the development of a sound program in medical education, adequate fiscal and physical resources, and the development of appropriate administrative procedures.

Provisional accreditation was received on April 6, 1978, and the first class was enrolled the following September. The charter class included 14 men and 10 women, whose ages ranged from 21-39 years: 19 were black, 3 were white, and two were other minorities. Sixteen were Georgia residents; eight had Masters Degrees. Our second class, admitted in September, 1979, includes 20 black students and four whites, of whom 19 are Georgia residents.

For the 24 places in the freshman class of 1979-80, the School of Medicine received almost 2,000 applications. An even larger number of applicants is expected for the class entering in September, 1980. The class size of the School of Medicine will peak at 80 in the mid-1980s.

Some 26 full time, 10 part time, and 53 volunteer faculty have been recruited from medical schools

* Dr. Sullivan is Dean and Director of the School of Medicine at Morehouse College. This paper was presented at the Annual Scientific Meeting of the Medical Association of Georgia on Nov. 15, 1979. Send reprint requests to Dr. Sullivan at 830 Westview Dr., SW, Atlanta, GA 30314.

around the country. The faculty have developed a curriculum which is designed to (1) provide the student with a comprehensive knowledge and understanding of biologic phenomena, (2) to assist the student in developing problem-solving skills and an attitude of life-long learning, (3) to develop in the student an appreciation for the many human factors which impinge upon the state of health or the reaction to illness in his or her patients. Approximately 40% of the curriculum is interdisciplinary, and the remaining 60% is discipline-oriented. Courses in medical humanities are included in the 2-year curriculum.

The School of Medicine is currently housed in temporary facilities on the Morehouse College campus. They include classrooms, student laboratories, a medical library, faculty offices and research laboratories, administrative offices, student tutorial offices, a student lounge, and apartments for student housing.

A 6.3 acre parcel of land, adjacent to the Morehouse campus, has been purchased for the future site of the medical school's campus. Groundbreaking for a $6.5 million basic medical sciences building is scheduled for the spring of 1980. The building will have 85,000 gross square feet and will include most of the above-listed institutional uses. Occupancy of this facility is scheduled for the fall of 1982.

The School of Medicine is affiliated with medical schools at Emory University, the Medical College of Georgia, Howard University, the University of Alabama in Birmingham, and Meharry Medical College, for the transfer of our students after completion of the first 2-years of medical studies. Additional medical school affiliations will be developed in the future to accommodate an increase in class size.

The long-range plans of the School of Medicine are to develop into a 4-year, M.D.-degree granting institution, as rapidly as resources permit. Our present plans are to initiate third year teaching in the summer of 1983 and to award the first M.D. from Morehouse in 1985.

The School of Medicine is developing teaching affiliations with Southwest Community Hospital, the Hughes Spalding Pavilion of Grady Hospital, Southside Comprehensive Health Center and the West End Health Center, all in Atlanta. Discussions have been initiated with hospitals and clinics in rural areas of Georgia and adjacent states, with the goal of developing remote sites for clinical training of our students, for clinical electives, and later, for third and fourth year clerkships.

In addition to undergraduate medical education, our priorities are to develop graduate programs in medical education, including residencies in family practice, and other specialties; to develop programs in continuing medical education, tailored to meet the needs of the busy practitioner; to develop teaching affiliations with other health professions schools for interdisciplinary education programs; and to develop affiliations with physicians, physician groups, clinics, and hospitals for the purpose of contributing to an improved level of health care and better access to health care for all Georgians including the poor and our minority citizens.

We are grateful to the Medical Association of Georgia for its interest, its support, and the opportunity to review our status and our plans for the future. The MAG's endorsements, encouragement, and financial support have been very important to our development and will continue to be so in the future. We look forward to the continued growth of our partnership with the members of the MAG in our mutual goals of improving health care, increasing access to health care, and improving the health status of our citizens.

CSBME Disciplinary Actions

At the request of the Composite State Board of Medical Examiners (CSBME) (the "Board") the Medical Association of Georgia has agreed to publish the results of disciplinary actions of the Board as a public service to inform physicians throughout the State of Georgia of the actions taken by the Board.

The disciplinary actions described below constitute the actions taken by the Board and are subject to appeal by the physicians involved to an appropriate superior court pursuant to the terms of the Georgia Administrative Procedure Act.

The following are actions taken between May 1, 1980, and May 30, 1980:

Revocation of License

David R. Hobbs, M.D., [Non-MAG Member]

Probation of License

James W. Richardson, M.D., [Non-MAG Member; Probation until Dec. 11, 1980.]

Pedro F. Rodriguez, M.D., [Non-MAG Member; (Probation indefinite — no Schedule II and III DEA registration)]

Voluntary Surrender

John A. Hockenhull, M.D., [MAG Member prior to May 14, 1980.]

Emergency Suspension

Jim T. Harrison, D.O. [Non-MAG Member]

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

R ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

CHOPPER ONE



ICU 101



PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO

AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

—— **CALL TOLL FREE** ——

GEORGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

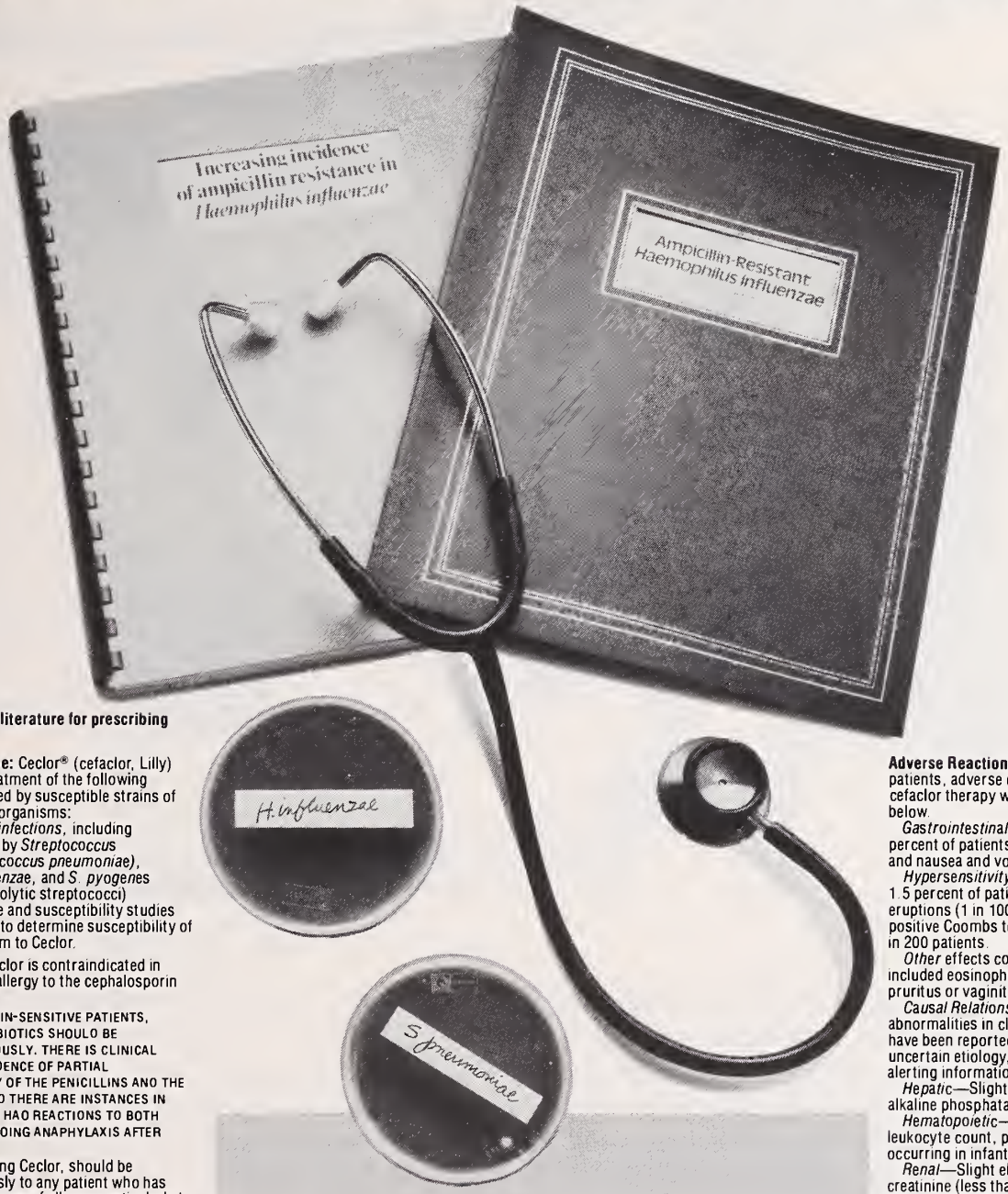
Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References
1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

000482



80%*

*80% of the stocks recommended by Robert D.Carl, III, during the past three years have been profitable. More importantly, **95%** of closed positions have been profitable. Mr. Carl, Executive Vice President of J. Gatsby & Co., is solely responsible for all final decisions regarding stocks recommended in **THE NEW CONTRARIAN**, a stock advisor newsletter published twice monthly in Atlanta and advertised nationally in **BARRON'S.** He is also President of Carl Investment Associates, Inc., an investment advisor firm managing portfolios for individuals, corporations, pension funds and trust funds. While it cannot be assumed that future recommendations will be profitable or as profitable as past selections, a copy of Mr. Carl's performance record and **A WORD ABOUT CONTRARY INVESTING** may be obtained by writing J. Gatsby & Co.

THE NEW CONTRARIAN
published by
J. GATSBY & CO.
(registered with the S.E.C.)
is an **exceptional** securities newsletter.

30 DAY
unconditional
100% CASH REFUND GUARANTEE

☐ Enclosed is check for $165 for 1 year subscription.
☐ Enclosed is check for $95 for 6 months subscription.

Circulation Dept., J Gatsby & Co
1054 First National Bank Building
Decatur, Georgia 30030

Name _____
Address _____
City _____ State _____ Zip _____

Medigram

DEAR DOCTOR...

INSIDE FIND PRELIMINARY PROGRAM OF 1980 MAG SCIENTIFIC ASSEMBLY.
NOVEMBER 21-23 AT OMNI INTERNATIONAL HOTEL, ATLANTA.

FEATURING:
- PROGRAMS IN 17 SPECIALTIES
- AMA CATEGORY 1 CREDIT
- AAFP AND ACEP CREDIT
- SPECIAL MAG SESSION: NUTRITION
- ALUMNI RECEPTIONS

IF YOUR RESERVATIONS ARE NOT MADE AT THIS DATE, DON'T DELAY.
COMPLETE ENCLOSED REGISTRATION FORM AND MAIL TODAY. DON'T
MISS THIS EXCITING, INFORMATIVE SCIENTIFIC ASSEMBLY.

M A G

DON'T MISS IT!

1980 MAG Scientific Assembly

SCHEDULE OF SESSIONS
1980 MAG Scientific Assembly

NOVEMBER 21-23, 1980 **OMNI INTERNATIONAL HOTEL**

FRIDAY A.M.	FRIDAY P.M.	SATURDAY A.M.	SATURDAY P.M.	SUNDAY
	Allergy/ Pediatrics	Plastic Surgery	1:00 p.m.: MAG Abner W. Calhoun Lecture	
	Chest Disease	Chest Disease	Special MAG Session: Nutrition	
Internal Medicine-Gastroenterology	Internal Medicine-Gastroenterology	Internal Medicine	Emergency Medicine	
	GSIM Luncheon 12 noon	Neurology-Neurosurgery	Neurology-Neurosurgery	Orthopedic Surgery
		Ophthalmology	Ophthalmology	
Otolaryngology	Otolaryngology			
		Pathology	Pathology	Pathology
Public Health		Psychiatry	Psychiatry	
Surgery	Surgery			
Urology		Urology		

MEDICAL ASSOCIATION of GEORGIA
Education Division

REGISTRATION FORM

1980 MAG Scientific Assembly

November 21 - 23, 1980
Omni International Hotel, Atlanta

1980 MAG Scientific Assembly

Name _____ (Last) _____ (First) _____ (MI)

Address _____

_____ Specialty _____

Registration fees:

- ☐ MAG member ($25) $ _____
- ☐ Non-member ($50) _____
- ☐ Resident, intern, student (no fee)
- ☐ Nurse, other health professional ($15) _____
- ☐ Speaker or program chairman (no fee)

Georgia Society of Internal Medicine
Luncheon, Friday ($12 each) _____
All physicians and spouses are invited to attend.

TOTAL $ _____

Checks should be made payable to the **Medical Association of Georgia**, and payment must accompany this form. There will be no refunds after November 18. Please detach and mail to:

MAG Scientific Assembly
938 Peachtree Street, N.E.
Atlanta, Georgia 30309

IMPORTANT: Please check the appropriate box(es). I plan to attend the following program(s):

- ☐ MAG Calhoun Lecture (1:00p.m. Saturday)

- ☐ Allergy
- ☐ Chest Disease
- ☐ Emergency Medicine
- ☐ Gastroenterology
- ☐ Internal Medicine
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Nutrition (MAG)
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Pathology
- ☐ Pediatrics
- ☐ Plastic Surgery
- ☐ Psychiatry
- ☐ Public Health
- ☐ Surgery
- ☐ Urology

MAKE YOUR RESERVATIONS EARLY!

PLEASE RESERVE HOTEL ACCOMMODATIONS AS CIRCLED

Medical Association of Georgia
Scientific Assembly
November 21-23, 1980

Name _____

Address _____

City _____ Telephone _____

Sharing room with _____

Method of payment _____

Credit card # _____ Expiration date _____

NOTE: Thursday reservations **MUST BE GUARANTEED.** Should the guest not arrive on this date or call in the cancellation before 6 p.m., he will be billed for both the guest room and tax.

Friday and Saturday reservations will be held until 6 p.m. unless guaranteed or covered by deposit.

Reservations received after 11-7-80 will be accepted on a space available basis.

Please circle room and rate desired. If not available, next room rate will be assigned. Room charges subject to applicable local and city taxes.

	Std.	Med.	Deluxe
Singles	$56	$62	$68
Doubles	68	74	80

Length of stay _____ nights

Arrival date _____

Arrival time _____

Guaranteed _____ (see NOTE)

If you have any questions concerning your reservations, please call the Omni International Hotel at 404/659-0000.



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 9024 ATLANTA, GA.

POSTAGE WILL BE PAID BY ADDRESSEE

RESERVATIONS DEPARTMENT

OMNI

INTERNATIONAL HOTEL

ONE OMNI INTERNATIONAL
ATLANTA, GEORGIA 30303

1980 MAG Scientific Assembly

PRELIMINARY PROGRAM

CONTENTS

General Information 682
MAG Abner W. Calhoun Lecture 683
Special MAG Session: Nutrition 689
Scientific Programs
Allergy 683
Chest Disease 684
Emergency Medicine 685
Gastroenterology 686
Internal Medicine 687
Neurology 688
Neurosurgery 688
Ophthalmology 689
Orthopedic Surgery 691
Otolaryngology 692
Pathology 692
Pediatrics 693
Plastic Surgery 693
Psychiatry 694
Public Health 694
Surgery 695
Urology 697

MAG PROGRAM CHAIRMEN

Allergy: BETTY B. WRAY, Augusta,
Allergy and Immunology Society of Georgia
Chest Disease: ROLAND S. SUMMERS, Savannah,
Georgia Thoracic Society and Georgia Chapter,
American College of Chest Physicians
Emergency Medicine: RAB CROSS, Atlanta,
Georgia Chapter, American College of Emergency Physicians
Gastroenterology: Z. M. KILPATRICK, Augusta,
Georgia Gastroenterologic Society
Internal Medicine: WILLIAM C. WATERS, III, Atlanta,
Georgia Chapter, American College of Physicians
DAVID M. TAYLOR, Atlanta,
Georgia Society of Internal Medicine
Neurology: ROBERT W. GILBERT, JR., Atlanta,
Georgia Neurological Society
Neurosurgery: F. PHILIP WIRTH, Savannah,
Georgia Neurosurgical Society
Nutrition: JUDSON G. BLACK, Atlanta,
MAG Committee on Nutrition
Ophthalmology: H. DWIGHT CAVANAGH, Atlanta,
Georgia Society of Ophthalmology
Orthopedic Surgery: WILLIAM C. COLLINS, Atlanta,
Georgia Orthopedic Society
Otolaryngology: WILLIAM E. SILVER, Atlanta,
Georgia Society of Otolaryngology,
Greater Atlanta Otolaryngology Society
Pathology: DWIGHT R. WEATHERS, D.D.S., Atlanta,
Atlanta Society of Pathologists
L. DAVID STACY, Atlanta,
Georgia Association of Pathologists
Pediatrics: JOSEPH H. PATTERSON, Atlanta,
Georgia Chapter, American Academy of Pediatrics
Plastic Surgery: JOHN M. GRIFFIN, Atlanta,
Georgia Society of Plastic Surgeons
Psychiatry: RONALD MILESTONE, Smyrna,
Georgia Psychiatric Association
Public Health: GUNAR N. BOHAN, Decatur,
Georgia Chapter, American Association of Public Health Physicians
Surgery: EUGENE D. DAVIDSON, Atlanta,
Georgia Chapter, American College of Surgeons
Urology: WOODROW W. PAYNE, Brunswick,
Georgia Urological Association

PLANNING COMMITTEE

ARTHUR J. MERRILL, JR., Atlanta, Chairman
EDWIN C. EVANS, Atlanta
JOHN T. GODWIN, Atlanta
ELLIS B. KEENER, Decatur
C. REX TEESLINK, Augusta
A. CALHOUN WITHAM, Augusta
STEPHEN L. DANIEL, Ph.D., Coordinator
SHEILA CARSON, Assistant Coordinator

GENERAL INFORMATION

INTRODUCTION

The Medical Assaciatian of Geargia cardially invites yau ta attend its 6th annual Scientific Assembly an Navember 21-23 at the Omni Internatianal Hatel in dawntawn Atlanta. The 1980 Scientific Assembly's continuing medical educatian pragram will feature scientific sessians in 17 specialties as well as a general sessian an the subject of nutritian. Each sessian will carry AMA Categary 1 credit. Physicians, spouses, families, and guests will enjoy the "Canventian City" and especially the Omni camplex with its many attractians.

The Omni Internatianal megastructure is a camplete entertainment center featuring a sparts camplex, ice skating rink, a variety af exclusive internatianal shaps and bautiques, Rizzali Internatianal Baakstare, six mavie theatres, and magnificent restaurants, such as Burt Reynalds' Place, Bugatti's, Mimi's, and the French Restaurant. As the site af a newly-apened MARTA Statian, the Omni is naw readily accessible by rapid rail transit from Peachtree Street, Georgia State University, and ather paints east and west. In order ta allaw appartunity far Christmas shapping, there are na farmal pragrams planned far spauses. All attendees shauld find this largest specialty graup meeting in Geargia bath educatianal and enjayable.

REGISTRATION

Please pre-register far the Assembly by campleting the registratian farm at the beginning af this program, detaching it fram the hatel reservatian farm, and mailing it with yaur registratian fee ta the MAG headquarters affice.

Registratian desks at the Assembly will be lacated at the Internatianal Pramenade in the Canventian Center af the Omni Internatianal Hatel. Registratian haurs will be Friday 7:30-5:00, Saturday 7:30-5:00, and Sunday 7:30-2:00.

The registratian fee far MAG members is $25. The fee far nan-members is $50. Fee far nurses and other health prafessianals will be $15. There is na fee far speakers, pragram chairmen, medical students, interns, ar residents wha have praper identificatian.

HOTEL RESERVATIONS

If yau wish hatel accammadatians, please camplete and detach the battam partian af the registratian form and mail it directly ta the Omni International Hotel by Navember 7, 1980. As stated an the hotel card, Thursday reservatians *must be guaranteed.* Shauld yau nat arrive an this date ar call in the cancellatian befare 6 p.m., yau will be billed far bath the roam and tax. Friday and Saturday reservatians will be held until 6 p.m. unless guaranteed ar cavered by depasit.

SPECIAL PROGRAMS

MAG Session: Nutrition — This year's Scientific Assembly features a general sessian an the topic of nutrition. The pragram, sponsared by the Medical Associotion of Georgio's Cammittee an Nutrition, will be held Soturdoy, November 22, 2:00-4:15, immediotely follawing the Colhaun Lecture. It includes Dr. C. Wayne Calloway addressing "Practical Nutritionol Assessment for Proctitioners," and Dr. Daniel Rudman addressing "Causes and Treotment of Secandary Malnutrition." The program ends with a panel discussion on "Nutrition and the Hospitalized Patient." Guests are encouraged to come.

GSIM Luncheon — Mervin Shalawitz, M.D., will be the guest speaker at the Geargia Society af Internal Medicine Lunchean an Friday, Navember 21. Dr. Shalawitz is Medical Director af Intergraup Prepaid Health Services, Inc., Skakie, Illinais, and Clinical Prafessor af Medicine, Stritch Schaal of Medicine, Layala University, Chicaga. His talk will be entitled, "The IPA Alternative — HMOs Are Here ta Stay!" Far further infarmatian, check the pragram on Internal Medicine.

SOCIAL FUNCTIONS AND TICKET INFORMATION

Luncheons have been scheduled by the Geargia Saciety af Internal Medicine, Geargia Chapter af the American Callege of Surgeans, Allergy and Immunalagy Saciety af Geargia, Geargia Neuralagical Saciety/Geargia Neurosurgical Society (receptian fallawed by lunchean), and Geargia Saciety af Ophthalmalagy. Please check individual specialty pragrams far more infarmatian.

Alumni receptians will be held Friday evening, Navember 21, by Emary University Schaal af Medicine, and the Medical Callege af Geargia. The Medical Callege af Geargia will spansar a dinner fallawing its receptian. Alsa, receptians are planned Friday, Navember 21, by the Geargia Saciety af Otalaryngalagy and the Georgia Tharacic Society/Geargia Chapter, American Callege af Physicians. (Please check each specialty pragram far further infarmatian.)

Reservatians for all functians (except the Geargia Saciety af Internal Medicine Lunchean) shauld be made with respective specialty saciety ar alumni graup. Please cantact the appropriate program chairman or alumni affice far mare infarmation. This infarmatian may alsa be abtained in the registratian area at the Assembly.

Tickets far the Geargia Society af Internal Medicine Lunchean an Friday, Navember 21, may be ardered an the registratian farm in this pragram. All prepaid tickets will be included in the registratian packet ta be abtained at the registratian desk ot the Assembly. Additianal tickets will alsa be available an a first-came, first-served basis in the registratian area. Infarmatian abaut the lunchean and guest speaker is listed under "Special Pragrams" in this sectian.

CREDIT

As an arganizatian accredited far cantinuing medical educatian, the Medical Assaciatian af Geargia designates all scientific pragrams as meeting the criteria far Categary 1 credit an an haur-far-haur basis far the Physician's Recagnitian Award af the American Medical Assaciatian. Far infarmation an CME credits given by the American Academy af Family Physicians and the American College of Emergency Physicians, please check individual pragrams.

EXHIBITS

Educatianal exhibits will be set up in the Narth Fayer an the ground floor af the Convention Center at the Omni International Hatel. There will be no technical exhibits.

MESSAGE CENTER

A message center will be maintained for the convenience of members and guests of the MAG ot the registrotion desk, located at the Internationol Pramenade in the Convention Center of the Omni International Hotel.

1980 ABNER W. CALHOUN LECTURE
Saturday, November 22, 1:00 p.m.



GEORGE L. BLACKBURN, M.D., PH.D.
Chief, Nutritian/Metabalism Labaratary, Cancer Research Institute, New England Deacaness Haspital, Baston, Massachusetts

"Biometric Measurements of Hospital Patient Risks: Need for Nutritional Assessment"

Dr. Gearge L. Blackburn, surgean and nutritianist fram Bastan, Massachusetts, will deliver the Abner W. Calhaun Lecture this year. He is ane af the innavatars and leaders in the field af nutritianal suppart far the critically-ill haspitalized patient.

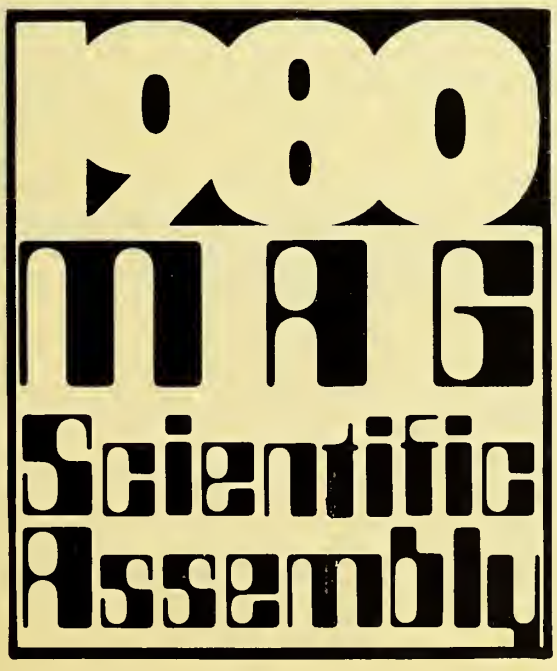
Dr. Blackburn received his M.D. degree at the University af Kansas and his Ph.D. degree in nutritianal biachemistry at the Massachusetts Institute af Technalagy. He did pastgraduate training at Boston City Haspital in general surgery. He holds memberships in many societies and is past president af the American Saciety of Parenteral and Enteral Nutritian.

Dr. Blackburn has published widely, and his research and publicatians have focused an the metabalic and nutritianal assessment of critically-ill haspitalized patients and the nutritianal treatment with intravenaus hyperalimentatian of thase nutritianally deficient fram a variety af causes, including sepsis, burns, cancer, and pastaperative G.I. tract surgical pracedures.

With the frequency af malnutrition in haspitalized patients, it is important far the physician to be able ta recagnize thase in need af nutritional suppart. Dr. Blackburn's lecture will address the basics and theary af nutritianal assessment.

All Scientific Assembly attendees, spauses, and guests are cardially invited ta attend the lecture.

Nate: This will be the first tapic af the Nutritian Pragram. See Special MAG Session: Nutritian.



ALLERGY

Allergy and Immunology Society of Georgia

Program Chairman
BETTY B. WRAY, Augusta

Guest Speaker
CHARLES D. BLUESTONE, Prafessar of Otalaryngalagy, University af Pittsburgh, Pittsburgh, PA

Friday, November 21, 12:00 NOON

A Joint Meeting of the
Allergy and Immunology Society of Georgia
and
Georgia Chapter, American Academy of Pediatrics

12:00 **LUNCHEON**

ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

Presiding:
Betty B. Wray
Department of Pediatrics
Medical College of Geargia
Augusta

1:30-2:20

ALLERGY AND RECURRENT OTITIS MEDIA

CHARLES D. BLUESTONE
Pittsburgh, PA

This discussian will include pathaphysialagy af the eustachian tube and middle ear, the relatianship af allergic disease ta recurrent atitis, and current cancepts af management.

2:20-2:30

QUESTIONS

2:30-2:45

ASPECTS OF DUST ALLERGY

FREDERICK C. HOUSE
President
Allergy and Immunalagy Saciety af Geargia
Augusta

Several different implicatians of dust allergy will be discussed.

2:45-3:05

BREAK

3:05-3:20

ELEVATED IgE AND RECURRENT INFECTIONS

MARGARET F. GUILL
Fellow in Allergy-Immunalagy
Medical College af Georgia
Augusta

Several different immune defects have been identified in patients with recurrent infectian and extreme elevatians af IgE.

3:20-4:10

MANAGEMENT OF THE CHILD WITH SEVERE REACTIONS TO INSECT STINGS

ROBERT E. REISMAN
Clinical Professor of Medicine & Pediatrics
State University of New York at Buffalo
Buffalo, NY

The speaker will discuss children who are at risk, who should be tested and treated with venom, and the different implications for children and adults with the problem.

4:10-4:20

QUESTIONS

4:20 **BUSINESS MEETING**

ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3.5 prescribed hours by the American Academy of Family Physicians.

CHEST DISEASE

Georgia Thoracic Society and Georgia Chapter, American College of Chest Physicians

Program Chairman
ROLAND S. SUMMERS, Savannah

Guest Speakers
JAMES W. WYNNE, Associate Professor, Department of Medicine and Anesthesiology, University of Florida, Gainesville, FL
THOMAS W. SHIELDS, Professor of Surgery, Chairman of Thoracic Surgery, Northwestern University Medical School; Chief of Surgery, Lakeside Veterans Hospital, Chicago, IL
RICHARD A. MATTHAY, Associate Professor, Department of Medicine, Associate Director, Pulmonary Medicine, Yale University School of Medicine, New Haven, CT

Friday, November 21, 1:00 P.M.

LUNG CANCER 1980

Presiding:
Roland S. Summers
Assistant Clinical Professor
Department of Medicine
Medical College of Georgia, Augusta
Memorial Medical Center, Savannah

1:00-1:30

LUNG CANCER 1980: WHERE ARE WE AND WHERE ARE WE GOING?

JAMES W. WYNNE
Gainesville, FL

1:30-2:30

LUNG CANCER: SURGICAL ASPECTS

THOMAS W. SHIELDS
Chicago, IL

2:30-2:45

BREAK

2:45-3:45

LUNG CANCER: IMMUNOTHERAPY: STATE OF THE ART

RICHARD A. MATTHAY
New Haven, CT

3:45-4:15
LUNG CANCER: PRE-OPERATIVE ASSESSMENT OF THE SEVERE CHRONIC LUNGER

JAMES W. WYNNE
Gainesville, FL

4:15-5:15 **BUSINESS MEETING**

GEORGIA THORACIC SOCIETY

Alan Plummer, presiding

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS
Fred Bloodworth, presiding

5:15 **RECEPTION**

GEORGIA THORACIC SOCIETY

GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Saturday, November 22, 9:00 A.M.

STATE OF THE ART: POTPOURRI OF PULMONARY MANIFESTATIONS

Presiding:
Anthony Costrini
Education Committee
Georgia Thoracic Society
Savannah

9:00-10:00

STATE OF THE ART: PHARMACEUTICAL MANIPULATION OF CARDIAC PERFORMANCE — OBSTRUCTIVE LUNG DISEASE — RADIONUCLEOTIDE ASSESSMENT

RICHARD A. MATTHAY
New Haven, CT

10:00-10:15

BREAK

10:15-11:15

STATE OF THE ART: THE SOLITARY PULMONARY NODULE

THOMAS W. SHIELDS
Chicago, IL

11:15-12:15

STATE OF THE ART: SLEEP APNEA SYNDROME

JAMES W. WYNNE
Gainesville, FL

This program has been partially funded through contributions from the Boeringer-Ingleheim Pharmaceutical Company, Key Pharmaceutical Company, and Stonsell's Oxygen Service.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 6 prescribed hours by the American Academy of Family Physicians.

EMERGENCY MEDICINE

Georgia Chapter, American College of Emergency Physicians

Program Chairman:
RAB CROSS, Eost Point

Saturday, November 22, 1:00 P.M.

SELECTED TOPICS IN INFECTIOUS DISEASES

Presiding:
Rab Cross
South Fulton Hospital
Eost Point

1:00-1:30

VISUAL CLUES TO INFECTIOUS DISEASE STATES

JONAS A. SHULMAN
Professor of Medicine
Director, Division of Infectious Diseases
Emory University School of Medicine
Atlonta

When entertoining o diagnosis of infection, very often the clinicion is offorded neither o grom stoin nor infected tissue or fluid. This discussion will focus upon a number of infectious diseases, both old and new, wherein diagnosis is greotly focilitated by inspection alone.

1:35-2:05

SEXUALLY TRANSMITTED DISEASE IN MALES

SUMNER E. THOMPSON, III
Chief, Clinicol Studies Section
Venereol Diseose Control Division, C.D.C.
Assistont Professor of Medicine
Division of Infectious Diseoses
Emory University School of Medicine
Atlanta

This tolk focuses upon the mojor diognostic problems of the male potient — genitol ulcers, urethritis, and epididymitis. Discussion will olso stress diseoses not usually considered venereol yet increosingly prevolent in the homosexual population — hepatitis B and bacteriol ond parasitic enteritis.

2:10-2:40

PNEUMONIA

CARL PERLINO
Assistont Professor of Medicine
Division of Infectious Diseoses
Emory University School of Medicine
Atlanto

A wide ronge of bocterio, with varying ontimicrobial sensitivity, con couse pneumonia in mon; hence, the theropeutic decision-moking process is frequently very difficult. Diognostic guidelines for initiol ontibiotic choice will be discussed.

2:45-3:00

BREAK

3:00-3:30

OUTPATIENT ANTIBIOTIC THERAPY

CARL PERLINO
Atlanto

A host of new antibiotics for orol use now confronts the physician. The advontoges, disodvontoges, and indicotions for o number of these ogents will be discussed as well os guidelines for ontibiotic use in the office or emergency room.

3:35-4:05

ACUTE DIARRHEAL SYNDROMES

JONAS A. SHULMAN
Atlanto

Acute wotery diorrheo is o common entity often producing consideroble potient morbidity. It confronts the clinician with o theropeutic dilemma — whether or not to employ antibiotics. This discussion presents o rotionol opprooch to the differentiol diognosis for vorious old ond new diarrheal syndromes ond guidelines for oppropriate therapy.

4:10-4:40

VAGINITIS

SUMNER E. THOMPSON, III
Atlanto

This session will stress the rapid diognosis and oppropriote treatment of the most common causes of vaginitis — Trichomoniasis, Candidiasis, ond Gardnerella *(Corynebacterium Vaginale)*. New concepts in etiology and treatment will be discussed.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3.5 prescribed hours by the American Academy of Family Physicians.

Program is acceptable for 3.5 Category 1 credit hours by the American College of Emergency Physicians.

GASTROENTEROLOGY

Georgia Gastroenterologic Society

Program Chairman
Z. M. KILPATRICK, Augusto

Guest Speaker
NORTON J. GREENBERGER, Chairman, Deportment of Medicine, College of Heolth Sciences, University of Kansos, Konsos City, KS

Friday, November 21, 9:00 A.M.

A Joint Meeting of the
Georgia Chapter, American College of Physicians
and the
Georgia Gastroenterologic Society

Presiding:
Z. M. KILPATRICK, F.A.C.P.
President
Georgio Gostroenterologic Society
Augusta

9:00-9:05

WELCOME

Z. M. KILPATRICK
Augusta

9:05-9:25

DRUGS AND THE STOMACH

NORTON J. GREENBERGER
Konsas City, KS

9:30-9:40

ANTIBIOTIC COLITIS

FRANCIS J. TEDESCO
Chief, Section of Gostroenterology
Medical College of Georgio
Augusta

Antimicrobiol agents hove been implicoted as etiologic agents in colitis soon after they become ovoilable. Recent work has shown that, in presence of certoin antimicrobial agents, *Clostridium difficile* appears to flourish ond produce a cytotoxin which has been found in the stools of the majority of potients with ontibiotic colitis. Newer theropeutic approaches ond their outcome will be discussed.

9:45-10:05

DRUGS AND THE LIVER

HENRY M. MIDDLETON, III
Assistant Chief, Gastroenterology
Veterans Administration Medicol Center
Associate Professor of Medicine
Medicol College of Georgia
Augusta

Drug-induced liver injury is o product of modern theropeutics, results from vorioble degrees of intrinsic toxicity ond host idiosyncracy, moy be related to a drug's metobolism and presents with characteristic patterns of hepotocellular/cholestotic injury. Diagnosis and monogement may be affected by each of these factors.

10:10-10:30

STEROIDS, ANTACIDS, AND THE BONES

NORTON J. GREENBERGER
Kansas City, KS

10:30-11:00

BREAK

DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY — CURRENT VIEWS

11:00-11:10

DIAGNOSTIC UPPER G.I. ENDOSCOPY

FRANCIS J. TEDESCO
Augusta

The upper gastrointestinol troct is now evoluated radiogrophicolly or endoscopicolly, and frequently by both methods. If diagnostic accurocy is the sole bosis of comparison, endoscopic diognosis is regorded os the most definitive. The relotive sensitivity of eoch modolity in the gastrointestinol bleeder ond the patient with dyspepsio will be ossessed. Guidelines for selection will be discussed.

11:15-11:25

ERCP

SCOTT W. BROOKS, JR.
Assistant Professor of Medicine
Emory University School of Medicine
Atlonto

ERCP has permitted visuolization of the pancreotic ducts os well os the bile ducts, permitting greoter precision in diagnosis. The circumstonces in which this relotively new diagnostic modolity ore most likely to be helpful will be outlined.

11:30-11:50

LOWER G.I. BLEEDING AND COLONOSCOPY

FRANCIS J. TEDESCO
Augusta

Rectal bleeding is a common presenting symptom. The usuol recommended work-up has generally included a coreful history, a digital rectal examination, a proctosigmoidoscopy, ond a barium enemo exomination. Unfortunotely, many coses remoin undiognosed. The use of total colonoscopy has increosed the yield of finding significant pathologic conditions including colon concer, polyps, vascular ectasio, ond inflommotory bowel disease in 30 to 45% of patients.

11:55-12:15

THERAPEUTIC ENDOSCOPY

SCOTT W. BROOKS, JR.
Atlonto

Removing polyps from the G.I. troct is now well estoblished. Electro-coogulation ond laser photo coogulation of actively bleeding lesions os well as lesions such os ongiodysplosia is now o reolity. Esophageol vorices moy be occluded by endoscopic sclerosis, and the ompullo of Vater may be opened by endoscopic sphincterotomy to permit possage of retoined stones and to relieve popillary stenosis. These newer modalities will be brought into contemporory focus.

12:15-12:30

PANEL

Questions and Answers

Presiding
WILLIAM C. WATERS, III, F.A.C.P.
Governor for Georgia
American College of Physicians
Atlanta

2:00-2:10

REMARKS BY:
H. HILT HAMMETT, JR.
President,
Medical Association of Georgia

2:15-2:35

EVALUATION AND MANAGEMENT OF MALABSORPTION

NORTON J. GREENBERGER
Kansas City, KS

2:40-3:00

CHRONIC ACTIVE LIVER DISEASE

HENRY M. MIDDLETON, III
Augusta

Chronic hepatitis involves a spectrum of abnormalities that range from benign and nonprogressive to severe and progressive. A reasonable approach to management is aided by correlation of this spectrum with published studies to date, especially as they relate to severity of disease and to etiology.

3:05-3:20

NEWER THERAPEUTIC AGENTS (Metoclopromide, Bethanechol, etc.)

NORTON J. GREENBERGER
Kansas City, KS

3:20-3:50

BREAK

3:50-4:05

LIVER IN CONGESTIVE HEART FAILURE

HENRY M. MIDDLETON, III
Augusta

Centrilobular hepatic injury is common in congestive heart failure and results from a combination of venous congestion and decreased hepatic blood flow. Its severity correlates roughly with severity of heart failure. Though typically overshadowed clinically by the heart failure, it may in specific incidences lead to difficulties in diagnosis and patient management.

4:10-4:40

DIABETES AND THE GUT

NORTON J. GREENBERGER
Kansas City, KS

4:40-5:00

PANEL

Questions and Answers

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician Recognition Award.

Program is acceptable for 5.5 prescribed hours by the American Academy of Family Physicians.

INTERNAL MEDICINE

Georgia Chapter, American College of Physicians

Program Chairmen

WILLIAM C. WATERS, III, Atlanta
DAVID M. TAYLOR, Atlanta

FRIDAY, NOVEMBER 21, 12:00 NOON

12:00 LUNCHEON

GEORGIA SOCIETY OF INTERNAL MEDICINE

"The IPA Alternative — HMOs Are Here to Stay!"

MERVIN SHALOWITZ, M.D.

Dr. Shalowitz' "view from the inside" address will focus on the alternative of prepaid health care in the ever-changing medical community, with emphasis on how physician practice may be affected over the next five years. Dr. Shalowitz is currently Medical Director of Intergroup Prepaid Health Services, Inc., Skokie, Illinois, and Clinical Professor of Medicine, Stritch School of Medicine, Loyola University, Chicago. He is a former trustee of the American Society of Internal Medicine and Senior Provider Consultant for IPA Development, Department of Health and Human Services (formerly HEW), Washington, D. C. All Assembly participants, spouses, and guests are invited to attend.

Saturday, November 22, 9:00 A.M.

9:00-9:45

(Topic to be announced)

9:45-10:20

(Topic to be announced)

10:20-10:30

BREAK

10:30-11:30

THE AMERICAN COLLEGE OF PHYSICIANS IN THE 1980'S

ROBERT MOSER, F.A.C.P.
Executive Vice President
American College of Physicians
Philadelphia, PA

11:30 **BUSINESS MEETING**

GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2 hours by the American Academy of Family Physicians.

Program is acceptable for 2.5 Category 1 credit hours by the American College of Emergency Physicians.

NEUROLOGY

Georgia Neurological Society

Program Chairman
ROBERT W. GILBERT, JR., Atlanta

Guest Speaker
WILLIAM MCKINNEY, Professor of Neurology, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, NC

Saturday, November 22, 9:00 A.M.

A Joint Meeting of the
Georgia Neurological Society
Georgia Neurosurgical Society

Presiding:
FREMONT P. WIRTH
Savannah

MOVEMENT DISORDERS

9:00-9:20

INTRODUCTION AND MEDICAL MANAGEMENT OF TORTICOLLIS

ROBERT W. GILBERT, JR.
Atlanta Neurological Clinic
Atlanta

9:20-10:05

SURGICAL TREATMENT OF TORTICOLLIS AND RELATED MOVEMENT DISORDERS

PHANOR PEROT, JR., M.D., PH.D.
Medical University of South Carolina
Charleston, SC

10:05-10:20

DISCUSSION

10:20-10:40

BREAK

NEWER DIAGNOSTIC IMAGING TECHNIQUES

10:40-11:25

NEUROSONOLOGY — AN UPDATE

WILLIAM MCKINNEY
Winston-Salem, NC

11:25-11:45

METRIZAMIDE CT SCANNING OF THE SPINE

GEORGE COX
St. Joseph's Hospital
Atlanta

11:45-12:00

DISCUSSION

12:00 **RECEPTION AND LUNCHEON**

GEORGIA NEUROLOGICAL SOCIETY

GEORGIA NEUROSURGICAL SOCIETY

1:30 **BUSINESS MEETING**

GEORGIA NEUROLOGICAL SOCIETY

NEWER DIAGNOSTIC IMAGING TECHNIQUES (Continued)

2:00-3:00

CLINICAL APPLICABILITY OF CAROTID ULTRASOUND

WILLIAM MCKINNEY
Winston-Salem, NC

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2.5 prescribed hours by the American Academy of Family Physicians.

NEUROSURGERY

Georgia Neurosurgical Society

Program Chairman
FREMONT P. WIRTH, Savannah

Guest Speaker
PHANOR PEROT, JR., M.D., PH.D., Professor and Chairman, Department of Neurosurgery, Medical University of South Carolina, Charleston, SC

Saturday, November 22, 9:00 A.M.

A Joint Meeting of the
Georgia Neurological Society
Georgia Neurosurgical Society

See Program under Neurology

12:00 **RECEPTION AND LUNCHEON**

GEORGIA NEUROLOGICAL SOCIETY

GEORGIA NEUROSURGICAL SOCIETY

1:30 **BUSINESS MEETING**

GEORGIA NEUROSURGICAL SOCIETY

2:00-2:30

MANAGEMENT OF CERVICAL SPINE INJURIES

PHANOR PEROT, JR., PH.D.
Chorleston, SC

2:30-4:00

OPEN SCIENTIFIC SESSION INVITING PRESENTATION PAPERS FROM MEMBERS

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3.5 prescribed hours by the American Academy of Family Physicians.

SPECIAL MAG SESSION: NUTRITION

Program Chairman
JUDSON G. BLACK, Atlonto

Saturday, November 22, 1:00 P.M.

Molnutrition is common omong hospitolized potients, ond recovery from o voriety of illnesses may be impoired unless o proper supply of nutrients is provided. The progrom on nutrition, sponsored by the Nutrition Committee of the Medical Associotion of Georgio, will deol with theoretical and procticol evoluotions of the nutritionol stotus of patients, ond couses of molnutrition ond their treotment.

Presiding:
ELAINE FELDMAN
Professor of Medicine
Chief, Section on Nutrition
Medicol College of Georgio
Augusto

1:00-1:45

1980 MAG CALHOUN LECTURE

BIOMETRIC MEASUREMENTS OF HOSPITAL PATIENT RISKS: NEED FOR NUTRITIONAL ASSESSMENT

GEORGE L. BLACKBURN, M.D., PH.D.
Chief, Nutrition/Metabolism Loboratory
Concer Research Institute
New Englond Deaconess Hospital
Boston, MA

2:00-2:45

PRACTICAL NUTRITIONAL ASSESSMENT FOR PRACTITIONERS

C. WAYNE CALLOWAY
Consultont, Division of Endocrinology ond Metabolism
Consultont, Nutrition Clinic and Nutrition Consulting Service
Moyo Clinic
Rochester, MN
Chairmon, Subcommittee on Educotion
Nutrition Coordinoting Committee
Notionol Institutes of Heolth
Bethesda, MD

2:45-3:30

CAUSES AND TREATMENT OF SECONDARY MALNUTRITION

DANIEL RUDMAN
Professor of Medicine and Surgery
Heod, Clinicol Research Unit
Emory University School of Medicine
Atlonta

3:30-3:45

BREAK

3:45-4:15

PANEL DISCUSSION: NUTRITION AND THE HOSPITALIZED PATIENT

Panel:
ELAINE FELDMAN
Atlanta
GEORGE L. BLACKBURN
Boston, MA
C. WAYNE CALLOWAY
Rochester, MN
DANIEL RUDMAN
Atlonto

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3 elective hours by the American Academy of Family Physicians.

OPHTHALMOLOGY

Georgia Society of Ophthalmology

Program Chairman
H. DWIGHT CAVANAGH, Atlonta

Guest Speaker
ROBERT MACHEMER, Professor ond Choirman, Deportment of Ophthalmology, Duke University School of Medicine, Durhom, NC

Saturday, November 22, 9:00 A.M.

RETINA-TRAUMA SESSION

Presiding:
H. DWIGHT CAVANAGH
Professor ond Choirmon
Deportment of Ophthalmology
Emory University School of Medicine
Atlanta

9:00-9:12

PERIPHERAL RETINA EXAM IN PSEUDO-APHAKIC EYES: ONE YEAR FOLLOW-UP

BRUCE BECKER
Atlonta

9:12-9:24

VITRECTOMY IN THE TREATMENT OF ENDOPHTHALMITIS

FRANK C. BELL
Atlanto

9:24-9:36

NEW TECHNIQUES IN ELECTROPHYSIOLOGY FOR OPHTHALMOLOGY

ARTHUR KOBLASZ, PH.D.
Atlanta

9:36-9:48

THE VALUE OF VITRECTOMY IN APHAKIC CYSTOID MACULAR EDEMA

WILLIAM S. HAGLER
Atlanta

9:48-10:00

UPDATE OF SURVIVAL STATISTICS OF MELANOMA PATIENTS STUDIED WITH P-32

WILLIAM S. HAGLER
Atlanta
ROBERT VANDERLINE
Atlanta
WILLIAM H. JARRETT, II
Atlanta

10:00-10:12

HEMENDOPHTHALMITIS MASQUERADING AS CHRONIC UVEITIS OR INFECTION

HENRY J. KAPLAN
Atlanta

10:12-10:24

VITRECTOMY FOR DIABETIC RETINOPATHY: CHANGING INDICATIONS AND RESULTS

TRAVIS A. MEREDITH
Atlanta

10:24-10:36

THE EFFECT OF VITRECTOMY ON ENDOTHELIAL CELL COUNT

THOMAS FRIBERG
Augusta

10:36-11:00

BREAK

11:00-11:12

PHOTORECEPTOR DISC SHEDDING AND RETINAL DISEASE

JOSEPH BESHARSE, PH.D.
Atlanta

11:12-11:24

CHOROIDAL TUMOR AND NEVUS OF OTA IN A BLACK FEMALE

EDWARD FINEBERG
Augusta
J. ALLEN STOCKS
Augusta

11:24-11:36

THE POST-MORTEM EXAMINATION OF AN EYE CONTAINING A SUCCESSFUL POSTERIOR CHAMBER IOL

F. PHINIZY CALHOUN, JR.
Atlanta

11:36-11:48

FIBROUS INGROWTH AFTER OCULAR TRAUMA

WILLIAM COLES
Atlanta

11:48-12:00

UNUSUAL CLOSED FRACTURES OF THE MEDIAL AND LATERAL ORBIT AND THEIR COMPLICATIONS

CLINTON D. MCCORD, JR.
Atlanta

12:00-1:00

THE CURRENT STATUS OF VITRECTOMY SURGERY

ROBERT MACHEMER
Durham, NC

1:00 **LUNCHEON**

GEORGIA SOCIETY OF OPHTHALMOLOGY

ANTERIOR SEGMENT SURGERY AND DISEASE

Presiding:
MALCOLM LUXEMBERG
Professor and Chairman
Department of Ophthalmology
Medical College of Georgia
Augusta

2:00-2:12

LIGHT TOXICITY AND POSSIBLE RELATIONSHIP TO ANTERIOR SEGMENT DISEASE

DAVID S. HULL
Augusta

2:12-2:24

THE CURRENT STATUS OF RADIAL KERATOTOMY — NATIONAL STUDY

GEORGE O. WARING
Atlanta

2:24-2:36

RADIAL KERATOTOMY — CAUTIOUS OPTIMISM

ROBERT H. MARMER
Atlanta

2:36-2:48

APHAKIC KERATOPLASTY: CHANGING INDICATIONS AND RESULTS

H. DWIGHT CAVANAGH
Atlanta

2:48-3:00

INTRALAMELLAR HYDROGEL IMPLANTS FOR THE CORRECTION OF APHAKIA

BERNARD E. MCCAREY, PH.D.
Atlanta

3:00-3:12

RED EYES AND SOFT CONTACT LENSES: CAUSES AND PREVENTION

LOUIS A. WILSON
Atlanta

3:12-3:24

EXPERIENCE WITH THE COOPER LENS IN APHAKIC PATIENTS

P. THOMAS MANCHESTER
Atlanta

3:24-3:36

THE USE OF ADJUSTABLE SUTURES IN STRABISMUS SURGERY

J. ALLEN GAMMON
Atlanta

3:36-4:00

BREAK

4:00-4:12

PREVENTION OF FLAT ANTERIOR CHAMBERS FOLLOWING FILTRATION SURGERY

DAVID G. CAMPBELL
Atlanta

4:12-4:24

CLOSURE OF CYCLODIALYSIS CLEFT BY THE ARGON LASER

THOMAS S. HARBIN, JR.
Atlanta

4:24-4:36

CATARACT SURGERY FOLLOWING SUCCESSFUL GLAUCOMA SURGERY

JOHN C. RIESER
Atlanta

4:36-4:48

CHIASMAL VISUAL FIELD DEFECTS IN MULTIPLE SCLEROSIS

ROBERT SPECTOR
Atlanta

4:48-5:00

EVALUATION OF CATARACT FORMATION BY MICRODENSITOMETRY, *IN VIVO*

SIDNEY LERMAN
Atlanta
OTTO HOCKWIN
Bonn, Germany

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 6.5 elective hours by the American Academy of Family Physicians.

ORTHOPEDIC SURGERY

Georgia Orthopedic Society

Program Chairman
WILLIAM C. COLLINS, Atlanta

Guest Speakers
ANDREW F. BROOKER, Assistant Professor of Orthopedic Surgery, Johns Hopkins University; Chief, Orthopedic Surgery, Baltimore City Hospital, Baltimore, MD
DAVIS A. FISCHER, Clinical Assistant Professor of Orthopedic Surgery, University of Minnesota; Orthopedic Surgery Staff, Hennepin County Medical Center, Minneapolis, MN
NOBLE HANSEN, Assistant Professor of Orthopedic Surgery, Johns Hopkins University; Staff Orthopedic Surgeon, Baltimore City Hospital, Baltimore, MD

Sunday, November 23, 8:30 A.M.

Presiding:
WILLIAM C. COLLINS
Northside Hospital, Atlanta
Scottish Rite Hospital, Atlanta

8:30-9:00

EXTERNAL FIXATION OF THE TIBIA: INDICATIONS AND RESULTS

ANDREW F. BROOKER
Baltimore, MD

9:00-9:30

EXTERNAL FIXATION OF THE FEMUR

NOBLE HANSEN
Baltimore, MD

9:30-10:00

HELPFUL HINTS AND POTENTIAL PITFALLS IN EXTERNAL FIXATION

DAVIS A. FISCHER
Minneapolis, MN

10:00-10:30

BREAK

10:30-1:00

LABORATORY SESSION: DEMONSTRATION AND APPLICATION OF TIBIAL FRAMES AND FEMORAL FRAMES

Presiding:
JEFFREY T. NUGENT
Piedmont Hospital
Atlanta

2:00-2:30

EXTERNAL FIXATION: USE IN THE UPPER EXTREMITY

ANDREW F. BROOKER
Baltimore, MD

2:30-3:00

EXTERNAL FIXATION OF THE PELVIS

NOBLE HANSEN
Baltimore, MD

3:00-3:30

DIRECTION OF EXTERNAL FIXATION, INCLUDING NEWER CONCEPTS AND FRAME DESIGN AND RESULTS

DAVIS A. FISCHER
Minneopolis, MN

3:30-4:00

BREAK

4:00-5:30

DEMONSTRATION OF EXTERNAL FRAME APPLICATION TO THE PELVIS
DEMONSTRATION OF EXTERNAL FRAME APPLICATION TO THE HUMERUS

Progrom is occeptable for Cotegory 1 credit on on hour-for-hour bosis for the AMA's Physicion's Recognition Aword.

Progrom is occeptable for 7 elective hours by the Americon Academy of Fomily Physicians.

Progrom is occeptable for 7 Cotegory 1 credit hours by the Americon College of Emergency Physicians.

OTOLARYNGOLOGY

Georgia Society of Otolaryngology
Greater Atlanta Otolaryngology Society

Program Chairman
WILLIAM E. SILVER, Atlonto

Guest Speakers
MARK MAY, Professor, Department of Otoloryngology, University of Pittsburgh School of Medicine, Pittsburgh, PA
MARK SINGER, Associote Professor, Chief of Heod ond Neck Surgery, Department of Otolaryngology, Indiona University School of Medicine, Indianapolis, IN

Friday, November 21, 10:00 A.M.

A Joint Meeting of the
Georgia Society of Otolaryngology
Greater Atlanta Otolaryngology Society

Presiding:
WILLIAM E. SILVER
Shallowford Community Hospitol, Atlanta
Northside Hospital, Atlanta

APPLIED PHYSIOLOGY FOR THE UPDATED TREATMENT OF FACIAL NERVE PROBLEMS — SURGICAL AND MEDICAL TREATMENT

10:00-10:30

REVIEW OF FACIAL NERVE PHYSIOLOGY

MARK MAY
Pittsburgh, PA

10:30-11:00

CLINICAL TESTS

MARK MAY
Pittsburgh, PA

11:00-11:45

SPECIFIC TREATMENT FOR FACIAL NERVE PROBLEMS

MARK MAY
Pittsburgh, PA

11:45-12:00

DISCUSSION

ENDOSCOPIC TREATMENT FOR VOICE REHABILITATION POST LARYNGECTOMY OR INTRADISCIPLINARY APPROACH TO VOCAL RESTORATION FOLLOWING TOTAL LARYNGECTOMY

1:30-2:00

REVIEW OF VOCAL REHABILITATION

MARK SINGER
Indianopolis, IN

2:00-3:00

VIDEO TAPE OF ENDOSCOPIC SURGICAL PROCEDURES

3:00-3:30

DISCUSSION

3:30-3:45

BREAK

3:45-4:30

CASE PRESENTATIONS AND SURGICAL TECHNIQUES

MARK SINGER
Indianopolis, IN

Progrom is acceptable for Cotegory 1 credit on an hour-for-hour bosis for the AMA's Physician's Recognition Aword.

PATHOLOGY

Georgia Association of Pathologists
Atlanta Society of Pathologists

Program Chairmen:
L. DAVID STACY. Atlonta
DWIGHT R. WEATHERS, D.D.S., M.S.D., Atlanto

Guest Speakers
CAROL K. PETITO, Deportment of Neuropothology, Cornell Medical School, The New York Hospital, New York, NY
VINCENT J. HYAMS, Choirmon, Otoloryngic Pathology Deportment, Armed Forces Institute of Pothology, Bethesda, MD

Saturday, November 22, 9:00 A.M.

Presiding:
L. DAVID STACY
Saint Joseph's Hospital
Atlanta

9:00-10:00

UNUSUAL INFECTIONS OF THE ORAL CAVITY AND HEAD AND NECK REGION

ZALE SMILACK, D.D.S.
Atlanta

Interesting cases of infections of the oral cavity and head and neck region will be presented. These cases will include aerobic as well as anaerobic inflammatory processes. Management will include obtaining the proper specimen and interpreting clinically significant organisms.

10:00-10:30

BREAK

10:30-11:30

ANAEROBIC INFECTIONS OF THE HEAD AND NECK REGION

V. R. DOWELL, JR., PH.D.
Chief of Enterobacteriology Branch
Center for Disease Control
Atlanta

Management of laboratory specimens where anaerobes are suspected will be discussed. Techniques of isolation, identification, and referring specimens to area reference laboratories will be discussed.

11:30-12:30

PANEL DISCUSSION: DIAGNOSIS, IDENTIFICATION, MANAGEMENT, AND TREATMENT OF INFECTIONS OF THE ORAL CAVITY AND HEAD AND NECK REGION

Panel:
ZALE SMILACK, D.D.S.
Atlanta
V. R. DOWELL, JR., Ph.D.
Atlanta
MICHAEL STARGEL
Atlanta
PATRICIA DUBOSE
Atlanta

2:00-3:00

PATHOLOGY OF CEREBRAL BLOOD VESSELS

CAROL K. PETITO
New York, NY

Discussion will concern small and large vessels of the cerebral circulation. Interesting aspects of medical pathology related to the cerebral blood vessels will be emphasized.

3:00-4:00

ANAEROBIC INFECTIONS AND BRAIN ABSCESSES

V. R. DOWELL, JR., PH.D.
Atlanta

A high percentage of brain abscesses show anaerobic organisms to be the etiologic agent. Common organisms encountered in brain abscesses, their management and laboratory importance will be discussed.

Sunday, November 23, 9:00 A.M.-4:00 P.M.

TUMOR LESIONS OF THE HEAD AND NECK REGIONS

ANNUAL SLIDE SEMINAR

ATLANTA SOCIETY OF PATHOLOGISTS

Discussant:
VINCENT J. HYAMS
Bethesda, MD

Discussion will center around previously submitted reports of cases of lesions of the head and neck region by local pathologists and Dr. Hyams. This was incorporated into slide sets prepared for purchase before the seminar. Clinical histories on all cases accompany the slide sets.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 11 elective hours by the American Academy of Family Physicians.

PEDIATRICS

Georgia Chapter, American Academy of Pediatrics

Program Chairman
JOSEPH H. PATTERSON, Atlanta

Guest Speaker
ROBERT E. REISMAN, Clinical Professor of Medicine and Pediatrics, State University of New York at Buffalo, Buffalo, NY

Friday, November 21, 1:30 P.M.

A Joint Meeting of the
Allergy and Immunology Society of Georgia
and
Georgia Chapter, American Academy of Pediatrics
See program under Allergy

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

PLASTIC SURGERY

Georgia Society of Plastic Surgeons

Program Chairman
JOHN M. GRIFFIN, Atlanta

Guest Speaker
MILTON T. EDGERTON, Professor and Chief, Department of Plastic Surgery, The University of Virginia, Charlottesville, VA

Saturday, November 22, 9:00 A.M.

Presiding:
JOHN M. GRIFFIN
West Paces Ferry Hospital
Atlanta

9:00-10:00

HEMANGIOMA — NEW METHODS OF TREATMENT

MILTON T. EDGERTON
Charlottesville, VA

10:00-10:30

BREAK

10:30-11:30

EAR RECONSTRUCTION — OLD AND NEW METHODS

MILTON T. EDGERTON
Charlottesville, VA

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2 elective hours by the American Academy of Family Physicians.

PSYCHIATRY

Georgia Psychiatric Association

Program Chairman
RONALD MILESTONE, Smyrna

Guest Speaker
C. DAVID JENKINS, PH.D., Director, Department of Behavioral Epidemiology, Boston University Medical Center, Boston, MA

Saturday, November 22, 9:15 A.M.

Presiding:
Ronald Milestone
Brawner Psychiatric Institute
Smyrna

9:15-10:15

SOCIAL FACTORS AND RISK OF CORONARY HEART DISEASE: CLINICAL RECOGNITION OF THE TYPE A PERSONALITY

C. DAVID JENKINS, PH.D.
Boston, MA

A review of the evidence for social factors in risk of coronary heart disease will be presented. The clinical concept of Type A personality will be reviewed and suggestions offered for recognition in clinical practice.

10:15-10:30

INTERMISSION

10:30-11:30

PANEL DISCUSSION

A discussion of the above presentation will be carried out with the speaker, Dr. Jenkins, a panel of local physicians in the field of heart disease, and the audience.

2:00-3:30

THE INCIDENCE OF TYPE A PERSONALITY IN THE PHYSICIAN POPULATION AND ITS IMPLICATIONS FOR RISK OF CORONARY DISEASE IN THIS GROUP

C. DAVID JENKINS, PH.D.
Boston, MA

Dr. Jenkins, a panel of local physicians, and the audience will engage in a discussion of current physician practice and the incidence of factors associated with Type A personality. There will be an opportunity for each participant to do a confidential self-rating of his/her Type A characteristics during the session.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3.5 prescribed hours by the American Academy of Family Physicians.

PUBLIC HEALTH

Georgia Chapter, American Association of Public Health Physicians

Program Chairman
GUNAR N. BOHAN, Decatur

Friday, November 21, 9:00 A.M.

Presiding:
WILLIAM R. ELSEA, M.D., M.P.H.
Commissioner of Health
Fulton County Health Department
Atlanta

9:00-9:15

WELCOME AND INTRODUCTION

WILLIAM R. ELSEA
Atlanta

9:15-10:00

EARLY IDENTIFICATION, TREATMENT AND PREVENTION OF CHRONIC DISABLING CONDITIONS: A Challenge to Public Health in the 1980's

R. DWAIN BLACKSTON
Medical Director
DeKalb Developmental Evaluation Center
for Children
DeKalb County Health Department
Decatur

Recent advances in the clinical and laboratory diagnoses of metabolic, cytogenetic, and dysmorphology syndromes have allowed earlier identification, treatment, and habilitation methods for these disorders. A public health model to demonstrate the methodology, positive outcomes, and preventive aspects in these exciting new fields will be presented.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 1.5 prescribed hours by the American Academy of Family Physicians.

SURGERY

Georgia Chapter, American College of Surgeons

Program Chairman
EUGENE D. DAVIDSON, Atlanta

Guest Speaker
JOHN H. DAVIS, Professor and Chairman, Department of Surgery, University of Vermont College of Medicine, Burlington, VT

Friday, November 21, 9:00 A.M.

Presiding:
JOHN DICKINSON
President
Georgia Chapter, American College of Surgeons
Rome

9:00-9:10

T.E.N.S. FOR POST-SURGICAL ANESTHESIA

JOSEPH G. BUSSEY, JR.
Austell

Post-surgical electrical nerve stimulation as a means of analgesia will be discussed in a group review of 232 patients. Comparison is made between the amount of medications used by controls and T.E.N.S. patients following surgical procedures. T.E.N.S. results in a significant reduction in pain medication.

9:10-9:15

DISCUSSION

9:15-9:25

VASOCONSTRICTORS TO IMPROVE LOCALIZATION OF INTRA-ARTERIAL RADIOACTIVE MICROSPHERES

EDGAR D. GRADY, M.D.
Georgia Institute of Technology, Atlanta
STEPHEN P. AUDA, M.D.
Georgia Institute of Technology, Atlanta
MR. WILLIAM CHEEK
Georgia Institute of Technology, Atlanta

Presentation by Dr. Grady

A method of administering high dose internal radiation by Yttrium 90 microspheres for the treatment of primary and metastatic tumors of the liver will be discussed. Experimental models will be mentioned, and the results in a small number of clinical patients will be presented.

9:25-9:30

DISCUSSION

9:30-9:40

TREATMENT OF DIFFICULT HIP FRACTURES AFTER TOTAL HIP ARTHROPLASTY — TYPE AND TIMING OF REVISION SURGERY

J. STEPHEN BETHEA, III
Southern Orthopedic Clinic
Atlanta

A discussion of 20 patients who underwent hip fracture in a site of a previously operated-on total hip arthroplasty will be discussed. Certain specific problems in the management of these patients will be examined and the types of therapy demonstrated.

9:40-9:45

DISCUSSION

9:45-9:55

TREATMENT OF CONGENITAL ABDOMINAL WALL DEFECTS

FRANKLIN J. STAR, Columbus
KENNETH L. GOLDMAN, Columbus

Presentation by Dr. Star

The diagnosis, management, and repair of 13 patients with gastroschisis and omphalocele will be discussed. A silastic pouch staged repair method is described.

9:55-10:00

DISCUSSION

10:00-10:10

TUBAL REANASTOMOSIS USING ABSORBABLE STENT

AMIR H. ANSARI
Director
Atlanta Fertility Institute
Atlanta

Twenty patients with previously divided fallopian tubes underwent tubal reanastomosis. Patency rate is extremely high with pregnancy having been achieved in 55% of these patients. Discussion of the methods involved will be presented.

10:10-10:15

DISCUSSION

10:15-10:25

AN OVERVIEW OF ARGON LASER TREATMENT FOR PORT-WINE STAIN

LOVIC W. HOBBY
Director
Laser Treatment Center
Atlanta

The use of the argon laser in the treatment of disfiguring port-wine stain will be examined. The improvement in results in the treatment of this lesion by this method will be demonstrated.

10:25-10:30

DISCUSSION

10:30-10:40

STARCH PERITONITIS

CHARLES R. UNDERWOOD, Marietta
EMERSON B. COCHRAN, Marietta

Presentation by Dr. Underwood

In spite of widespread publicity about starch peritonitis, this entity still may be a clinical problem. The recognition and diagnosis of this entity and its treatment will be discussed.

10:40-10:45

DISCUSSION

10:45-11:00

The winning paper of the competition among residents in surgical disciplines in the state of Georgia, as yet to be selected, will be presented in this time period. Selection will be announced in the final program.

11:00-11:30

DIAGNOSIS AND CARE IN THE MULTIPLY-INJURED PATIENT

JOHN H. DAVIS
Burlington, VT

An overview discussion of the rapid management and care of the multiply-injured patient will be given.

11:30-12:00

POSTOPERATIVE SEPSIS

H. HARLAN STONE
Professor of Surgery
Emory University
School of Medicine
Atlanta

Postoperative sepsis accounts for much of the morbidity and mortality in trauma victims as well as emergent and elective surgical cases. The recognition, diagnosis, and therapy for postoperative sepsis will be discussed.

12:00 **LUNCHEON**

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Presiding:
LAMAR S. McGINNIS, JR.
Secretary
Georgia Chapter, American College of Surgeons
Atlanta

2:00-2:30

THE CARE AND MANAGEMENT OF THE BURN PATIENT

RICHARD TREAT
Assistant Professor of Surgery
Medical College of Georgia
Augusta

The initial care and management of the burn patient and the burn itself will be discussed, along with the entire care and management of burn patients.

2:30-2:55

THE MANAGEMENT OF MAJOR SOFT TISSUE INJURIES

FOAD NAHAI
Assistant Professor of Surgery-Plastic Surgery
Emory University School of Medicine
Atlanta

Modern methods of initial and delayed wound management and coverage have enabled surgeons to care for massive defects which were once extremely difficult to manage. Illustrative cases will be presented.

2:55-3:25

THE CARE AND MANAGEMENT OF VASCULAR INJURY

JOHN H. DAVIS
Burlington, VT

Vascular trauma is a common problem presented to emergency departments. The recognition, diagnosis, and management of these injuries will be discussed.

3:25-3:40

BREAK

3:40-4:10

THE MANAGEMENT OF CENTRAL NERVOUS SYSTEM TRAUMA

GEORGE TINDALL
Professor of Surgery-Neurosurgery
Emory University School of Medicine
Atlanta

The recognition, care, and management of patients with central nervous system trauma will be presented, and cases will be illustrated.

4:10-4:40

INJURIES TO THE DUODENUM AND PANCREAS

H. HARLAN STONE
Professor of Surgery
Emory University School of Medicine
Atlanta

Penetrating and blunt traumatic injuries to the duodenum and pancreas stretch the skills and imagination of the trauma surgeon extensively. The recognition, care, and management of these devastating injuries will be examined.

4:40-5:10

PANEL DISCUSSION ON TRAUMA PATIENTS

Panel:
JOHN H. DAVIS
Burlington, VT
H. HARLAN STONE
Atlanta
RICHARD TREAT
Augusta
FOAD NAHAI
Atlanta
GEORGE TINDALL
Atlanta

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 6 elective hours by the American Academy of Family Physicians.

Program is acceptable for 6 Category 1 credit hours by the American College of Emergency Physicians.

UROLOGY

Georgia Urological Association

Program Chairman
WOODROW W. PAYNE, Brunswick

Guest Speakers
PETER T. SCARDINO, Assistant Professor, Urology, Baylor College of Medicine, Houston, TX
KEITH LIGHT, Assistant Professor, Urology, Baylor College of Medicine, Houston, TX

Friday, November 21, 9:30 A.M.

Presiding:
Woodrow W. Payne, President
Georgia Urological Association
Brunswick

Ronald Roper, Secretary
Georgia Urological Association
Marietta

9:30-10:30

TESTICULAR TUMOR MARKERS — OLD AND NEW

PETER T. SCARDINO
Houston, TX

10:30-10:45

BREAK

10:45-11:45

INTERSTITIAL AND EXTERNAL RADIATION FOR LOCALIZED CARCINOMA

PETER T. SCARDINO
Houston, TX

Saturday, November 22, 9:30 A.M.

9:30-10:30

EVALUATION AND TREATMENT OF IMPOTENCE

KEITH LIGHT
Houston, TX

10:30-10:45

BREAK

10:45-11:45

URODYNAMICS AND PHARMACOLOGY IN NEUROGENIC BLADDERS — ARE DRUGS OF ANY USE?

KEITH LIGHT
Houston, TX

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 4 elective hours by the American Academy of Family Physicians.

"Clinicians must be aware of this syndrome, since invasive procedures such as surgery will turn chronic DIC into an acute, severe process."

Smoldering DIC Associated With Widespread Colonic Mucinous Adenocarcinoma

J. S. KRAUSS, M.D., C. R. BAISDEN, M.D., L. B. OTKEN, M.D., and O. E. TALLEDO, M.D., *Augusta**

THE ASSOCIATION of smoldering disseminated intravascular coagulation (DIC) and carcinoma is well-known.[1] The following is a report of this association with widespread colonic mucinous adenocarcinoma.

Report of a Case

A 29-year-old gravida III, para II, abortus 0 woman (MJB, 250-039) who was about 30 weeks gestation by her last menstrual period entered the Eugene Talmadge Memorial Hospital in Augusta. Her chief complaint was excessive increase of abdominal girth for the past several weeks. Physical findings included a 12 cm. abdominal mass. Fetal heart tones were heard. Hematologic studies demonstrated a slight prolongation of the activated partial thromboplastin time (aPTT) and increased fibrin split products (FSP) (Table 1). Chemical studies showed increased LDH, alkaline phosphatase, and hypoalbuminemia. White cells were present in the urine. Cultures of urine and blood specimens grew Klebsiella which was successfully treated by antibiotics.

One day after admission, the patient delivered a 500 gm. infant which subsequently died. Colonic biopsy, performed on her sixteenth hospital day, was interpreted as "mucinous adenocarcinoma" (101382). Four days later, an exploratory laparotomy was performed with segmental resection of colon, bilateral salpingo-oophorectomy, and peritoneal biopsy. The interpretation was "mucocellular carcinoma of colon with circumferential infiltration to the serosa; metastatic carcinoma to ovaries, bilateral, massive, infiltrating carcinoma in peritoneum" (101452) (Figure 2). One day later gastric hemorrhage and hypotension developed. Hematologic studies showed anemia, thrombocytopenia, occasional schistocytes, rare nucleated red cells (Figure 3), prolongation of both the protime (PT) and aPTT, and hypofibrinogenemia (Table 1). Heparin and packed red cells were administered; the patient improved clinically; her coagulation studies improved, although they never returned to normal

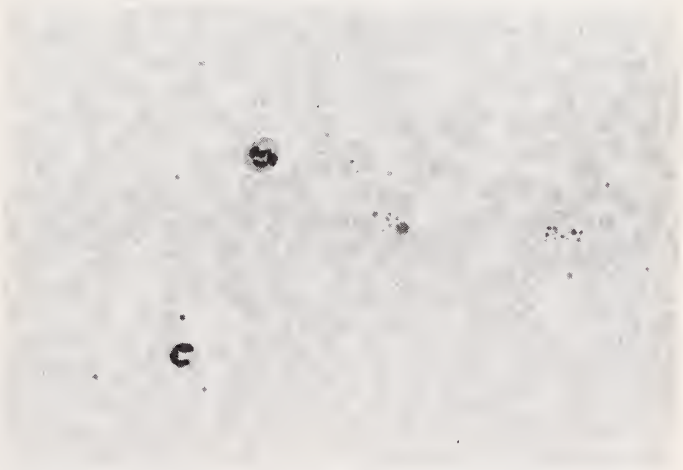


Figure 1 — Blood smear, Wright's stain. Magnified 600x. Day 1 — Note the thrombocytosis and large platelet near the center.

* Dr. Krauss is Assistant Professor and Drs. Baisden, and Otken are Associate Professors in the Department of Pathology, Medical College of Georgia. Dr. Talledo is a Professor in the Department of OB-GYN, at MCG. Address all requests for reprints to J. S. Krauss, M.D., Dept. of Pathology, Medical College of Georgia, Augusta, GA 30912.

TABLE 1
Laboratory Data

Test	Normal Values	Hospital Day 1	Day 24	Day 34
Hgb	12-16 gm/dl	9.6	9.4	11.3
WBC	4,800-10,800/ul	22,900	9,600	15,800
Platelet Count	150,000-400,000/ul	520,000	16,000	168,000
PT	10-14 sec	10.	49	17
aPTT	25-35 sec	37.	>100	44
Fibrinogen	200-400 mg/dl	600	60	
FSP	<10 ug/ml	>40		
LDH	102-200 mU/ml	750	1,000	355
SGOT (AST)	7-40 mU/ml	26	1,465	125
Alk. Phos.	28-100 mU/ml	155	62	114
Albumin	4.2-5.4 g/dl	2.3	3.3	3.2

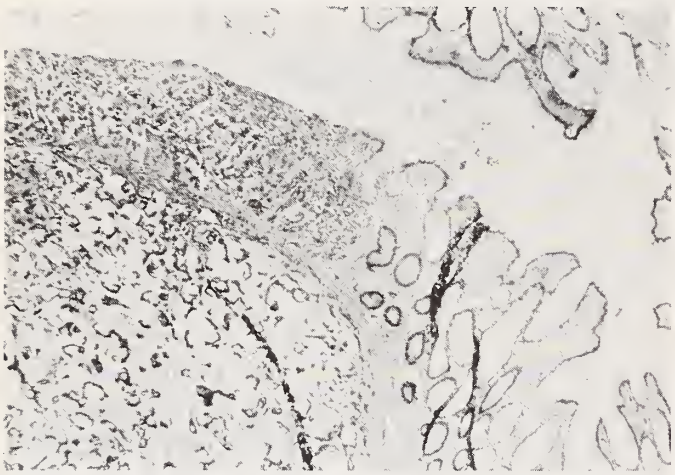


Figure 2 — Histologic section, Hematoxylin and Eosin. Magnified 150x. Mucinous adenocarcinoma of the colon.



Figure 3 — Blood smear, Wright's stain. Magnified 600x. Note the thrombocytopenia, occasional schistocytes, and the nucleated red cell.

(Table 1). Her LDH and SGOT remained elevated. She survived for 2 weeks postoperatively; on her 37th hospital day she died suddenly.

Comment

Unfortunately, there was no autopsy. The clinical history here, however, is consistent with the following set of events. This individual had "chronic," "compensated," or "smoldering" DIC[2] as a result of widespread mucinous adenocarcinoma. Mucin itself has been shown to have procoagulant activity.[3] Moreover, another procoagulant, protein A, has also been isolated from tumors.[4] Prior to surgery, the large platelets and slight prolongation of the activated PTT were suggestive of chronic DIC. Surgery converted this smoldering process into acute, fulminant DIC, resulting in hemorrhage, hypotension, and hepatic dysfunction, causing the terminal prolongation of the PT and aPTT. The acute DIC, however, responded to heparin.

DIC is a poorly understood process. It is thought to involve circulating activated procoagulants resulting in increased turnover of coagulation factors, including fibrinogen and platelets.[5] Smoldering DIC is commonly associated with widespread tumor. Clinicians must be aware of this syndrome, since invasive procedures such as surgery will turn chronic DIC into an acute, severe process. Chronic DIC, however, is difficult to diagnose without turnover studies involving radiolabelled platelets or fibrinogen. New instruments, like the Coulter S-Plus can measure platelet size. Thus, smoldering DIC could be detected by increased platelet size, possibly consistent with a younger platelet population,[6] suggestive of increased platelet destruction. Radioimmunoassays for activated coagulation factors such as thrombin,[7] or products of thrombin's action on fibrinogen, such as fibrinopeptide A,[8] or for platelet products like platelet factor 4 (PF_4),[9] or beta-thromboglobulin (B-TG)[9] now exist. A combination of platelet sizing and radioimmunoassay could be used to screen selected patients for smoldering DIC and avert the problems that occurred in this case.

Summary

A case of smoldering DIC associated with metastatic mucinous adenocarcinoma is reported. It is suggested that surgery converted chronic DIC to acute, fulminant DIC. The clinician should be aware of chronic intravascular coagulation syndromes. Laboratory tests to screen for smoldering DIC are suggested.

References

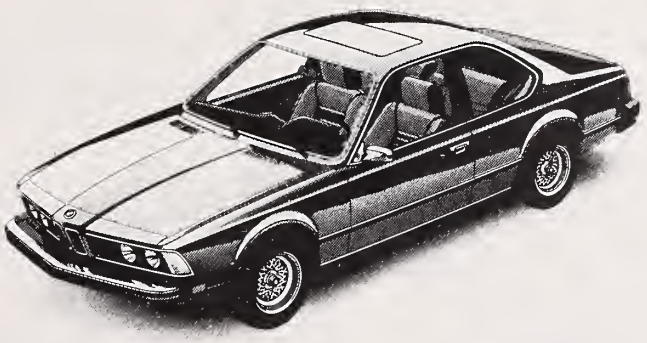
1. Sack GH, Levin J, Bell WR. Trousseau's syndrome and other manifestations of chronic disseminated coagulopathy in patients with neoplasms: clinical pathophysiologic and therapeutic features. Medicine 1977; 56:1-37.
2. Cooper, HA, Bowie EJW, Owen CA. Evaluation of patients with increased fibrinolytic split products (FSP) in their serum. Mayo Clin Proc 1974; 49:654-657.
3. Pineo GF, Regoeczi E, Hatton MWC, et al.: The activation of coagulation by extracts of mucus: a possible pathway of intravascular coagulation accompanying adenocarcinomas. J Lab Clin Med 1973; 82:255-266.
4. Gordon SG, Franks JJ, Lewis B: Cancer procoagulant A: a factor X activating procoagulant from malignant tissue. Thromb Res 1975; 6:127-137.
5. Krauss JS, Walker DW: Miliary tuberculosis and consumption of clotting factors by multifocal vasculopathic coagulation. Southern Med J 1979; 72:1479-1481.
6. Detwiler TC, Odell TT, Jr., McDonald TP: Platelet size, ATP-content, and clot retraction in relation to platelet age. Am J Physiol 1962; 203:107-110.
7. Shuman MA, Majerus PW: The measurement of thrombin in clotting blood by radioimmunoassay. J Clin Invest 1976; 58:1249-1258.
8. Nossel HL, Yudelman I, Canfield ER, et al.: Measurement of fibrinopeptide A in human blood. J Clin Invest 1974; 54:43-53.
9. Sixma JJ: Techniques for diagnosing prethrombotic states: a review. Thrombos Haemost 1978; 40:252-259.

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



BMW

THE ULTIMATE DRIVING MACHINE.

BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730

Are you paying taxes on your savings interest again this year?

If so, you need to learn about Fulton Federal's Tax Deferrer. It's a savings plan that lets you defer taxes on your interest until you are in a lower tax bracket. With a minimum deposit of $5,000, your funds will be invested in the highest yield for which your account qualifies.* (There's a small annual service fee, as well as a one-time processing fee.) For more information, call or come by the Fulton Federal branch nearest you.

*A substantial interest penalty is required for early withdrawal.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta
P.O. Box 1077 • Atlanta, Georgia 30301 • 404-586-7283

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

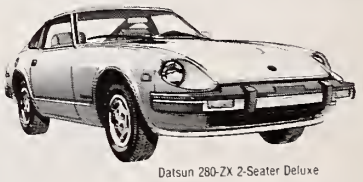
2690 Cumberland Parkway

Atlanta, Georgia 30339

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!


Have a Coke®
and a smile.
Coke® adds life.
registered trade-marks which identify the same product of The Coca-Cola Company.

A careful review of the patient's home environment, renal function, and concomitant medication should be made before prescribing oral diabetic agents.

Oral Diabetic Agents: More Dangerous in the Elderly Than Recognized

GEORGE S. WALKER, III, M.D., *Eastman**

Abstract

A recent review of the charts of hypoglycemic patients in a small community hospital turned up an alarming number of sulfonylurea-induced cases which had occurred under a variety of circumstances. Phenylbutazone was frequently a precipitating drug when given with the sulfonylurea. Clofibrate was also implicated. It was also learned that treatment for chlorpropamide-induced hypoglycemia should be more vigorously pursued, and therapy should be continued for 3-5 days. Physicians should be more aware of drug interactions with oral hypoglycemic agents.

Since the sulfonylureas were found to lower serum glucose levels, some physicians have been uncertain about whether or not to use these agents to lower the serum glucose in diabetics. Several years ago, the University Group Diabetes Program created much controversy and, in the end, left some confusion about the use of oral hypoglycemic agents.

The purpose of this article is neither to condemn nor condone oral agents but to point out the recognized complications of hypoglycemia that occur with these drugs under certain circumstances. It is known that the use of these agents can lead to hypoglycemia in patients with: impaired renal function; inadequate calorie intake; endocrine deficiencies; and in those taking potentiating drugs.

* Dr. Walker practices internal medicine. His address is 107 Professional Center Dr., Eastman, GA 31023.

In spite of this common knowledge, errors in the use of oral agents still occur. The problem was pointed out several years ago by Seltzer in a review of 473 cases of drug-induced hypoglycemia. In this paper, we are looking at nine cases of hypoglycemia which were all induced by an oral agent under a variety of circumstances.

Method

In a review of the incidence of hypoglycemia in a county hospital, we discovered an alarming number that were related to oral agents. The charts were reviewed for the circumstances surrounding each case.

Results

As can be seen from Table 1, almost all patients (88%) were over 60 years of age. This reflects the increasing necessity of therapy for glucose intolerance in the elderly. (The risk of death seems to be related to blood glucose around 20 mg% or lower and probably, to some degree, the risk is related to the duration of hypoglycemia. The duration of this is relatively difficult to document.) Out of nine cases, six were known to be related to chlorpropamide. The BUN was elevated in 55%. Phenylbutazone was most often (44%) associated as an additional inducing agent for hypoglycemia. It is interesting to note that clofibrate was associated in 22% of the cases. Most of the therapy consisted of one or two infusions of D50W, although therapy in Case #3 was more vigorous, which probably reflects difficulty in keeping blood glucose at acceptable levels.

Comment

As stated earlier, 88% of the patients were at least

TABLE 1 — Summary of Hypoglycemic Reactions

Patient #	Race yr. Sex	BS	CPK	SGOT	BUN/Crea.	Oral Agent	Other Drugs	Status	Duration	RX
1	70 W/F	28	19	54	18	Tolazamide	Isosorbide Dinitrade, Reserpine, Imipramine	Living	1 day	Sweetened liquids
2	63 B/M	27	56	198	?	Chlorpropamide	Phenyl-butazone	Living	1 day	D50W D10W
3	80 B/M	11	9,700	9,500	25/1.5	Chlorpropamide	Phenyl-butazone	Deceased	2 days	D50W Decadron D10W
4	70 B/F	32	?	24	58	?	?	Living	1 day	D50W sweetened liquids
5	56 W/F	20	?	94	23	Chlorpropamide	?	Living	1 day	D50W
6	70 B/F	19	?	44	44/1.6	Chlorpropamide	Phenyl-butazone	Deceased	?	?
7	79 W/F	33	65	65	32/?	Chlorpropamide	Clofibrate	Living	1 day	D50W
8	63 B/F	34	41	41	42/1.8	Acetohexamide Chlorpropamide	Pheny-butazone, Clofibrate	Living	?	D50W D10W
9	69 W/F	30	?	22	20	Chlorpropamide		Living	<1 day	D50W

60 years of age. This is not surprising, since most diet-controllable diabetics range in age from late middle-age to quite elderly. Frequently, patients in this age group do not eat regularly and many times take medications from various physicians who are not aware of this "overlap." In addition, many elderly patients have osteoarthritis, and they often try a variety of medications to alleviate their aches and pains. For these reasons, physicians should closely question all of their elderly patients about the medications they are taking and warn them about the potential dangers of drug interaction.

Blood sugars were well documented within the hypoglycemic range. It seems that blood sugars less than 20 mg% were particularly lethal, since 100% of these who had such low levels died. The duration probably plays a more important role, however, than just an isolated severe hypoglycemia. It appears that the combination of being aged, having decreased renal function, and taking chlorpropamide and phenylbutazone is a combination that leads to severe hypoglycemia. With this combination of circumstances, one should probably begin infusion of D50W through a CVP line until blood glucose has stabilized. The line should be left in place until all danger of recurrent hypoglycemia has disappeared.

Many of the patients in the survey (44%) had elevated BUNs. Physicians should screen renal function to avoid prescribing potentiating oral agents for elderly patients with renal disease.

Chlorpropamide was implicated most frequently (78%) in these drug-induced cases. This has been a frequent offender noted in the literature and often has been associated with potentiating agents such as bishydroxy coumarin or phenylbutazone which displaces the chlorpropamide from its protein carrier. It has a relatively long half life of 35 hours and is excreted exclusively by the kidneys. In addition, acetohexamide metabolism by-products are excreted by the kidneys. These by-products are capable of producing hypoglycemia.

The most common potentiating drug was phenylbutazone (44%), and was associated with both deaths. This occurs because of both the high incidence of arthritis and the onset of diabetes in the elderly. Frequently these patients are taking a medication for their arthritic pain, and may not be aware of the complications associated with combining the oral agents and phenylbutazone. It is their physician's responsibility to keep them informed.

Clofibrate was given concomitantly in two cases. It is possible that some of the metabolic products of clofibrate also aid in inducing hypoglycemia, due to the displacement of chlorpropamide from its protein carrier. It is known that the metabolic product of p-chlorophenoxy isobutyric acid is primarily bound to plasma albumin. This might potentially play a role in producing hypoglycemia. In one case, this was associated with phenylbutazone, but in Case #7, it was associated with the oral agent, Dymelor, alone. This area may need further investigation.

In Case #3, the patient had CPK's of 9,500 which were skeletal muscle on isoenzyme differentiation. I presume that the severe hypoglycemia associated with acidosis provided sufficient insult to the patient's metabolism to produce muscle injury and a

subsequent rise in CPK.

Therapy should consist of D50W in most cases, followed by close observation. In those cases where the agent is chlorpropamide associated with a potentiating agent and renal disease, a CVP line should probably be inserted and D50W run at a rate to keep urines 1-2+ in glucose content for 3-5 days. The patients must be observed closely for recurrence of hypoglycemia.

In summary, those patients at extreme risk for drug-induced hypoglycemia are (1) those over 60 years of age, since they may have poor calorie intake, may take more medication than prescribed due to confusion, and may sometimes live alone so that hypoglycemic attacks may go unnoticed for extended periods; (2) those patients who have renal disease; and (3) those taking multiple medications.

Bibliography

1. Schen RJ, Benaroya Y. Hypoglycaemic coma due to chlorpropamide: observations on twenty-two patients. Aging 1976; 5(1):31-6.
2. Bierman EL. The oral antidiabetic agents. AM Fam Physician 1976; 13(1):98-104.
3. Schen RJ, Khazzam AS. Postoperative hypoglycaemic coma associated with chlorpropamide. Br J Anaesth 1975; 47(8):899-900.
4. Walfish PG, Kashyap RP, Greenstein S. Sulfonylurea-induced factitious hypoglycemia in a nondiabetic nurse. Can Med Assoc J 1975; 112(1):71-2.
5. Scott D, Thomas M. Letter: The dangers of hypoglycaemia on oral hypoglycaemia agents. NZ Med J 1974; 80(522):187.
6. Kumar D, Mehtalia SD, Miller LV. Serum chlorpropamide in drug-induced hypoglycemia. J Assoc Physicians India 1973; 21(3):275-9.
7. Forman BH, Feeney E, Boas L. Letter: Drug-induced hypoglycemia. JAMA 1974; 229(5):522.
8. Scoville AB Jr. Editorial: Oral therapy in diabetes mellitus. South Med J 1974; 67(6):635-8.
9. Tannenbaum H, Anderson LG, Soeldner JS. Letter: Phenylbutazone-tolbutamide drug interaction. N Engl J Med 1974; 290(6):344.
10. Tashima CK. Hypoglycemia and probable lactic acidosis during phenformin therapy. Hawaii Med J 1973; 32(5):332-4.
11. Schen RJ. Letter: Chlorpropamide hypoglycaemia. Lancet 1973; 2(833):850-1.
12. Haunz EA. Chlorpropamide hypoglycaemia. Lancet 1973; 2(819):46-7.
13. Schen RJ. Chlorpropamide: dangerous hypoglycaemia in old age? Lancet 1973; 1(812):1121.
14. Goldberg LD, Alterman SL. Concurrent hypoglycemia and lactic acidosis in a diabetic treated with chlorpropamide and phenformin. South Med J 1973; 66(2):190-2.
15. Seltzer HS. Drug-induced hypoglycemia. A review based on 473 cases. Diabetes 1972; 21(9):955-66.
16. Stocks AE, Martin FI. Hypoglycaemia due to erroneous drug ingestion. Med J Aust 1972; 1(24):1256-8.
17. Wales JK. Mode of action of chlorpropamide in the treatment of diabetes insipidus. Proc R Soc Med 1971; 64(10):1070-1.
18. Arky RA, Arons DL. Hypoglycemia in diabetes mellitus. Med Clin North AM 1971; 55(4):919-30.

Tenuate®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema, *Endocrine:* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily; swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

9-4672 (Y957A)

Overweight may not always be simple... complications can develop.*

Complicated or not...

Tenuate® Dospan® ©IV

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

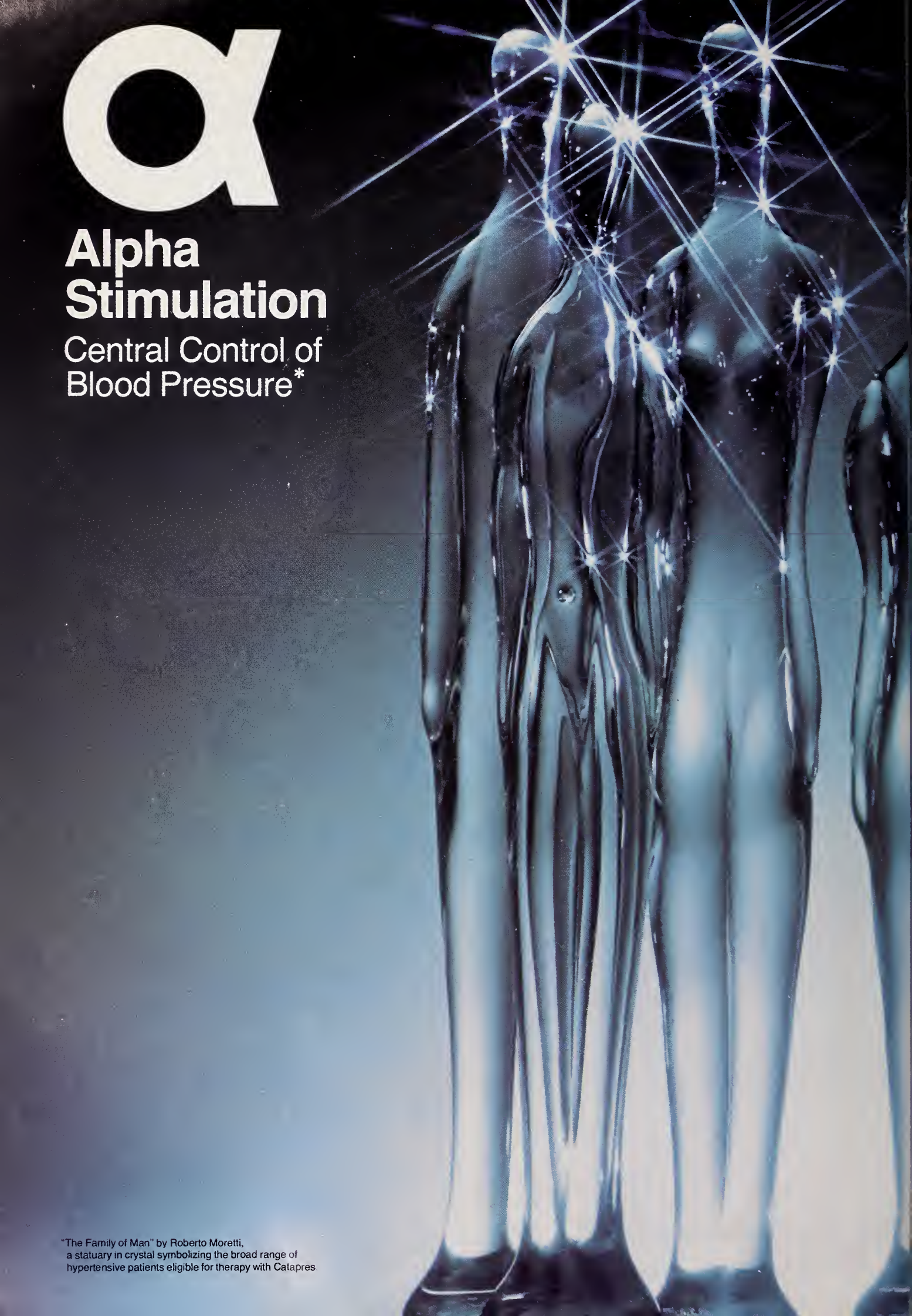
*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

Alpha Stimulation

Central Control of Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets

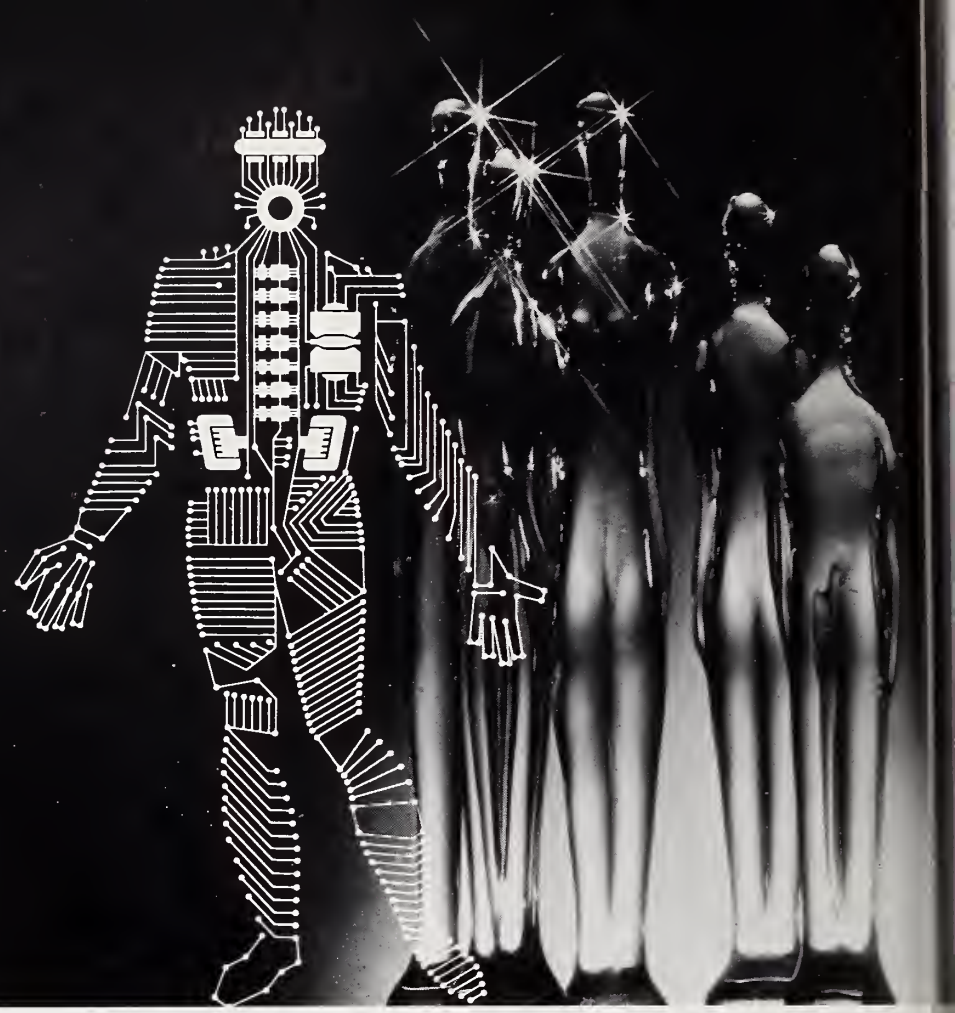


Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension

The Alpha Advantage:

It's for all kinds of hypertensives



Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities of liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes: nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

BOEHRINGER INGELHEIM

Boehringer Ingelheim

Boehringer Ingelheim Ltd
Ridgefield, CT 06877

The Confidentiality of Medical Review Committee Proceedings Under Georgia Law

ROBERT N. BERG and DENNIS L. ZAKAS, *Atlanta**

In a recent decision, *Eubanks v. Ferrier,*[1] the Supreme Court of Georgia for the first time interpreted the extent of confidentiality accorded to the proceedings of medical review committees by *Ga. Code Ann.* §88-3204.[2] As most physicians are aware, medical review committees are established to foster the delivery of quality health care services by providing a method for the review of medical care. Confidentiality is necessary to insure that committee members freely exchange information without fear of their testimony being used as evidence in a civil suit.

Background: *Ga. Code Ann.* §88-3204

Ga. Code Ann. §88-3204 was enacted in recognition of the medical review committee's need for confidentiality. This statute provides that "the records of . . . [medical review] committees shall not be subject to discovery, or introduction into evidence in any civil action against a provider of professional health services arising out of matters which are the subject of . . . review by . . . [the] committee."[3] Moreover, the statute prohibits all persons in attendance at medical review committee proceedings from testifying in a civil action as to "evidence . . . presented during the [committee] proceedings . . . or as to any findings, recommendations, evaluations, opinions, or other actions of such committee or any members thereof."[4]

The privilege of confidentiality accorded by the medical review committee statute (the "Statute") is not absolute, however. "[I]nformation, documents, or records otherwise available from original sources are not immune from discovery . . . merely because they were presented during the proceedings of such committee."[5] Furthermore, the Statute specifically allows a medical review committee member to testify at trial as to matters within his knowledge, as long as his answers do not concern "his testimony before such committee or opinions formed by him as a result of said committee hearings."[6]

The Facts of *Eubanks V. Ferrier*

In *Eubanks v. Ferrier,* Mrs. Eubanks sued Dr. Ferrier for the wrongful death of her husband, who was a patient at a local hospital. Mrs. Eubanks claimed that Dr. Ferrier's negligent treatment of her husband resulted in his death.

As is common practice, the hospital review committee conducted an in-house investigation of Mr. Eubanks' death. The committee was composed of three doctors, one of whom had previously treated Mr. Eubanks. Believing the commit-

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an Associate and Mr. Zakas is a Summer Associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

tee's findings to be favorable to her case, Mrs. Eubanks attempted to subpoena and take the depositions of the doctors who had served on the committee.

The hospital sought to intervene in the *Eubanks* lawsuit for the sole purpose of obtaining a protective order which would prohibit the three physicians from testifying about their activities as members of the review committee. The trial court granted the hospital's motion and entered a protective order prohibiting Mrs. Eubanks' attorney from deposing the two committee members who had not treated her deceased husband. Inquiries directed toward the third committee member were limited to his treatment of the deceased; Mrs. Eubanks' attorney could not question him about any matter that arose from his service on the committee.

Mrs. Eubanks appealed, claiming that the Statute according privilege to medical review committee members violated her constitutional rights and alleging that the trial court misapplied the Statute in considering her case.

Constitutionality of *Ga. Code Ann.* §88-3204

The Georgia Supreme Court rejected Mrs. Eubanks' claim that the Statute was unconstitutional. According to the Court, the Statute granting privilege to medical review committees would be constitutional, as long as it had "a reasonable relation to a proper legislative purpose."[7] The purpose of the Statute was "to foster the delivery of quality medical services by preserving the candor necessary for the effective functioning of hospital medical review committees."[8] The Court held that this was a "proper legislative purpose, and [that] making the records and proceedings of the medical review committees privileged and nondiscoverable certainly has a real and substantial relation to that object."[9]

The Court weighed the benefits associated with this legislative purpose against the potentially detrimental impact of the Statute on a plaintiff's ability to obtain evidence and determined that these potential hardships were not sufficient to counterbalance the Statute's benefits. After all, the Statute did not deprive individuals of access to the courts; it merely restricted the sources of evidence available to a plaintiff in a malpractice suit. This was a small hardship in comparison with the necessity of confidentiality to the proceedings of medical review committees. To the extent that the Statute represented a rational exercise of legislative power, without infringing on Mrs. Eubanks' legal rights, the Statute was constitutional, concluded the Court.

Application of the Statute

Having concluded that *Ga. Code Ann.* §88-3204 was constitutional, the Court faced the question of whether the trial court had applied the Statute correctly in prohibiting Mrs. Eubanks' attorney from freely deposing the committee members. Essential to the resolution of this question was the Court's interpretation of one key statutory provision: "nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge."[10]

The Court held that this provision restricted the otherwise blanket protection accorded to committee members by the Statute. A correct application of the Statute would have allowed committee members to be "call[ed] as expert witnesses, on the same basis as other expert witnesses."[11] Committee members could therefore be asked "hypothetical questions based on facts in evidence which are obtained from nonprivileged sources,"[12] as long as "no reference . . . [is made] to their membership on the committee."[13] On the basis of this statutory interpretation, the Court overruled the trial court's decision to issue the protective order and allowed the plaintiff to pose certain hypothetical questions to the members of the committee.

Conclusion: *Eubanks* and the Continuing Viability of Hospital Medical Review Committees

An interpretation of the Statute consistent with the trial court's decision could have resulted in unfairness to plaintiffs in malpractice suits. A plaintiff is required

to produce expert testimony in order to successfully assert a malpractice suit. Had the Statute extended a blanket privilege to all members of a medical review committee, many plaintiffs would be deprived of that right. A small town, for example, might have only one hospital. The administrators of that hospital could immunize staff physicians from having to testify by making them members of the hospital review committee. As a result, a plaintiff in a malpractice case might not be able to subpoena or depose any of the hospital's physicians. The plaintiff would be forced to employ physicians from other parts of the country as expert witnesses. Although this is permitted in Georgia, juries are often less inclined to believe an outsider's testimony than the expert testimony of a physician practicing in the community. By insuring the availability of local expert testimony, the *Eubanks* decision does accord some protection to plaintiffs in malpractice cases.

At the same time, the decision in *Eubanks* to uphold the constitutionality of *Ga. Code Ann.* §88-3204 represents a major victory for medical review committees. Also, while *Eubanks* does strike a balance between the plaintiff's need for expert testimony and the review committee's need for confidentiality, that balance may be weighted slightly in favor of the committee. *Ga. Code Ann.* §88-3204 limits a physician's testimony to knowledge obtained and opinions formed outside of the committee. The *Eubanks* Court's interpretation of the Statute further confines the testimony of a committee member to answering hypothetical questions based on facts obtained from nonprivileged sources. Thus, although the Court declined to grant absolute immunity from testifying to committee members, it appears that *Eubanks* preserved the confidentiality necessary for medical review committees to function properly.

Footnotes

1. Case No. 35989, ___ Ga. ___ (May 7, 1980).
2. *Ga. Code Ann.* §88-3204 extends the privilege of confidentiality to all medical review committees. Although the facts of *Eubanks* concern the effect of the statute on *hospital* medical review committees, the conclusions reached here apply to all medical review committees.
3. *Ga. Code Ann.* §88-3204.
4. *Id.*
5. *Id.*
6. *Id.*
7. *Eubanks v. Ferrier,* Case No. 35989, ___ Ga. ___ (May 7, 1980), at 6.
8. *Id.*
9. *Id.*
10. *Ga. Code Ann.* §88-3204
11. *Eubanks v. Ferrier,* Case No. 35989, ___ Ga. ___ (May 7, 1980), at 8.
12. *Id.*
13. *Id.*

REG NO

THE DEVEREUX FOUNDATION

ARIZONA
CALIFORNIA
CONNECTICUT
GEORGIA

PENNSYLVANIA

MASSACHUSETTS
TEXAS
ARKANSAS

M ..

DATE....

Age Pre-Adolescents Adolescents & Young Adults

℞

HEDGES TREATMENT CENTER

Intensive psychiatric care for youths and young adults in transition, those who are not fully ready to utilize a conventional residential treatment approach but whose problems are not severe enough to warrant psychiatric hospital attention.

M.D.

℞ Age 17-24

CAREER HOUSE

For intellectually bright high school graduating seniors, and post-high school youth with problems of underachievement and/or personal adjustment. Psychotherapy, academic and vocational counseling. Arrangements made for enrollment in local colleges and career schools.

M.D.

Age Under 10

℞

CENTER FOR AUTISTIC AND SCHIZOPHRENIC CHILDREN

A comprehensive, short-term, residential treatment program for severely disturbed children under ten years of age.

M.D

℞ Age Adolescents and Adults

EDWARD L. FRENCH REHABILITATION CENTER

C. A. R. F. Approved

Residential and day programs. Comprehensive vocational evaluation, training and placement services. Opportunities for social adjustment training, work adjustment training, and sheltered employment.

M.D

. . . And many more separate day and residential treatment programs **prescriptively planned** for children and young adults with emotional and mental disabilities

Helena T. Devereux
Founder

Joseph B. Ferdinand
President

FOR INFORMATION AND LITERATURE:

National Director of Admissions is Charles J. Fowler, whose office is headquartered in Devon, Pa. 19333

PENNSYLVANIA Ellwood M. Smith, Admissions Director, Devon, Pa. 19333 or call 215 687-3000
CALIFORNIA Keith A. Sealon, Admissions Director, Box 1079 Santa Barbara 93102or call 805 968-2525
TEXAS Betty H. Templin, Admissions Director, Box 2666, Victoria 77901 or call 512 575-8271
ARIZONA Richard A. Etter, Director, 6436 E. Sweetwater, Scottsdale 85254 or call 602 948-5857
GEORGIA Ralph L. Comerford, Director, 1980 Stanley Road, N. W., Kennesaw 30144 or call 404 427-0147
CONNECTICUT Theodore E. Enoch, Director, Sahbaday Lane, Washington 06793 or call 203 868-7377
MASSACHUSETTS Frederic A. Hervey, Director, Miles Road, Rutland 01543 or call 617 886-4746

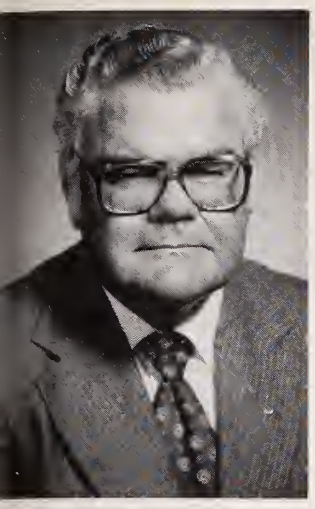
. . . Carrying the Promise of Happy Tomorrows



THE DEVEREUX FOUNDATION

A NONPROFIT ORGANIZATION

All Devereux Branches Surveyed by the Joint Commission on Accreditation of Hospitals are Approved as Psychiatric Facilities for Children and Adolescents



president's letter

Let's Stay Cool — But Involved

Every physician is a member of a profession of real service to mankind — Medicine.

Our job, our colleagues, and most certainly our patients, are very important.

But regarding this profession of medicine. How do I relate to it? With involvement, commitment, sincerity, interest?

Am I a member of my profession just because I pay my dues when I send in my check?

I contend that every physician must be constantly involved and alertly informed to provide to the American public workable voluntary solutions to health care problems.

Why?

The diversified positions of American medicine and federal government repetitiously present us with the necessity to realistically assess our attitudes and directions by active informed involvement.

There actually are not any new realities.

For 3 decades, most government bureaucracies and politicians have sought to change, by their domination, health care in this country.

The accumulated facts are that their changes are too often made intolerable by the way they offer them.

That is why every physician must accept the challenge and continue to seek to preserve quality health care in a free enterprise environment.

The tragic direction of regulation after regulation on every facet of our democracy by the state and federal governments must be opposed.

Responsive and honest opposition is not just our job. It is our responsibility.

In all health matters, our profession must be the conscience of the whole community by constantly pressing for voluntary solutions to problems.

I believe the problem is not the underrated people. The problem is the overrated government.

Our profession has a commitment to freedom.

Freedom to grow within the federation of medicine.

Freedom to share in the free enterprise system.

Freedom to fulfill our First Amendment obligations and to flourish with the opportunities of freedom.

The First Amendment is the cornerstone of democracy and inherently involves a serious responsibility. It is our guarantee to freedom.

Hippocrates said:

"Wherever the art of medicine is loved,
there is also love for Humanity."

I believe that is what our profession is all about.

To preserve our profession, our rights, and our freedom, physicians must be actively and constantly involved.

Respectfully,



H. Hilt Hammett, Jr, M.D.
President, M.A.G.

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

NEW MEMBERS

Almario, Vicente, Jr., Muscogee—S—
Martin Army Hospital, X-Ray Dept., Fort Benning 31905

Berggren, Ralph E., Bibb—ACT—FP
Mercer University Medical School, Macon 31207

Cross, George L., III, MAA—S—ORS
U.S. Army Hospital, Ft. Stewart 31313

Gur-Lavi, Meir, MAA—A—
3207 Henderson Mill Rd., Atlanta 30341

Guyton, Robert A., MAA—N-2—TS
25 Prescott St., NE, Atlanta 30308

Hakim, Faez, Dougherty—N-2—PTH
Palmyra Park Hospital, Albany 31702

Hammond, Dewey, Walker-Catoosa-Dade—N-2—FP
LaFayette Medical Center, LaFayette 30728

Hockett, William J., Lumpkin—ACT—R
Lumpkin County Hospital, Dahlonega 30533

Malone, Brian T., MAA—ACT—AN
3138 Verdun Dr., NW, Atlanta 30305

Metcalfe, James K., Whitfield-Murray—N-2—CLP
P.O. Box 1168, Dalton 30720

Peisel, Francis J., Ga. Medical Society—N-1—AN
8 Stephenson, Savannah 31401

Rosenthal, David, MAA—N-1—OS
Ste. 412, Baptist Professional Bldg., 315 Boulevard, NE, Atlanta 30312

Sarma, Pudipeddi R., MAA—S—HEM/ON
1670 Clairmont Rd., Decatur 30033

PERSONALS

First District

Waynesboro physician **Shelley A. Griffin, M.D.,** was recently named a Fellow of the American Academy of Pediatrics.

Fifth District

On July 1, **Robert Cowgill, M.D.,** of Atlanta, and his family left for a 2-year stay in Saudi Arabia. Dr. Cowgill will practice oncologic surgery at the King Faisal Specialist Hospital and Research Center. **John T. Godwin, M.D.,** will join him and head up the pathology department.

Chenault William Hailey, M.D., an Atlanta dermatologist, has been named to a 5-year term to the Board of Directors of the Medical College of Georgia Foundation, Inc.

Luella Klein, M.D., F.A.C.O.G., of Atlanta, was recently elected to a second term as Assistant Secretary of the American College of Obstetricians and Gynecologists.

Atlanta physician, **Peter MacWilliams, M.D.,** was recently elected Chief of the Medical Staff at Parkway Regional Hospital.

After 32 years of practice in Brookhaven, **C. A. N. Rankine, M.D.,** retired.

At its third Annual Awards Banquet, June 20, five MAG members were honored for having contributed 20 years or more to the Emory dermatology program, particularly in training residents. Recipients of these distinguished service awards were **Hiram Sturm, M.D.,** for 22 years service; **Chenault W. Hailey, M.D.,** for 20 years; **Harold B. Levin, M.D.,** for 32 years; **Joseph L. Rankin, M.D.,** for 33 years; **Philip H. Nippert, M.D.,** for 44 years; and **Herbert S. Alden, M.D.,** for 49 years.

Sixth District

Ralph Warnock, M.D., Thomaston, spoke to the Upson County Chapter of the American Diabetes Association on June 17. His subject was "Insulin Dependent Diabetics."

Seventh District

Craig Collier, M.D., recently discharged from the U.S. Army, has opened his practice in Calhoun.

Calhoun physician, **W. D. Hall, M.D.,** was honored recently when one of his patients, the 92-year-old Mrs. Sallie Black, presented him with a plaque.

Marvin M. Mitchell, M.D., Austell, was elected Secretary of the Medical Staff at Parkway Regional Hospital.

Eighth District

P. K. Batra, M.D., Baxley, vascular surgeon, recently announced plans to move to New York where he will be associated with the Lutheran Medical Center in Brooklyn for one year.

Channing S. Jun, M.D., Eastman, spoke to the Fitzgerald Rotarians at their June 17 meeting. His topic was acupuncture.

Tenth District

Robert C. McGahee, M.D., Augusta, retired after 50 years of pediatric practice.

Serving the General Insurance needs of
the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR AGENT

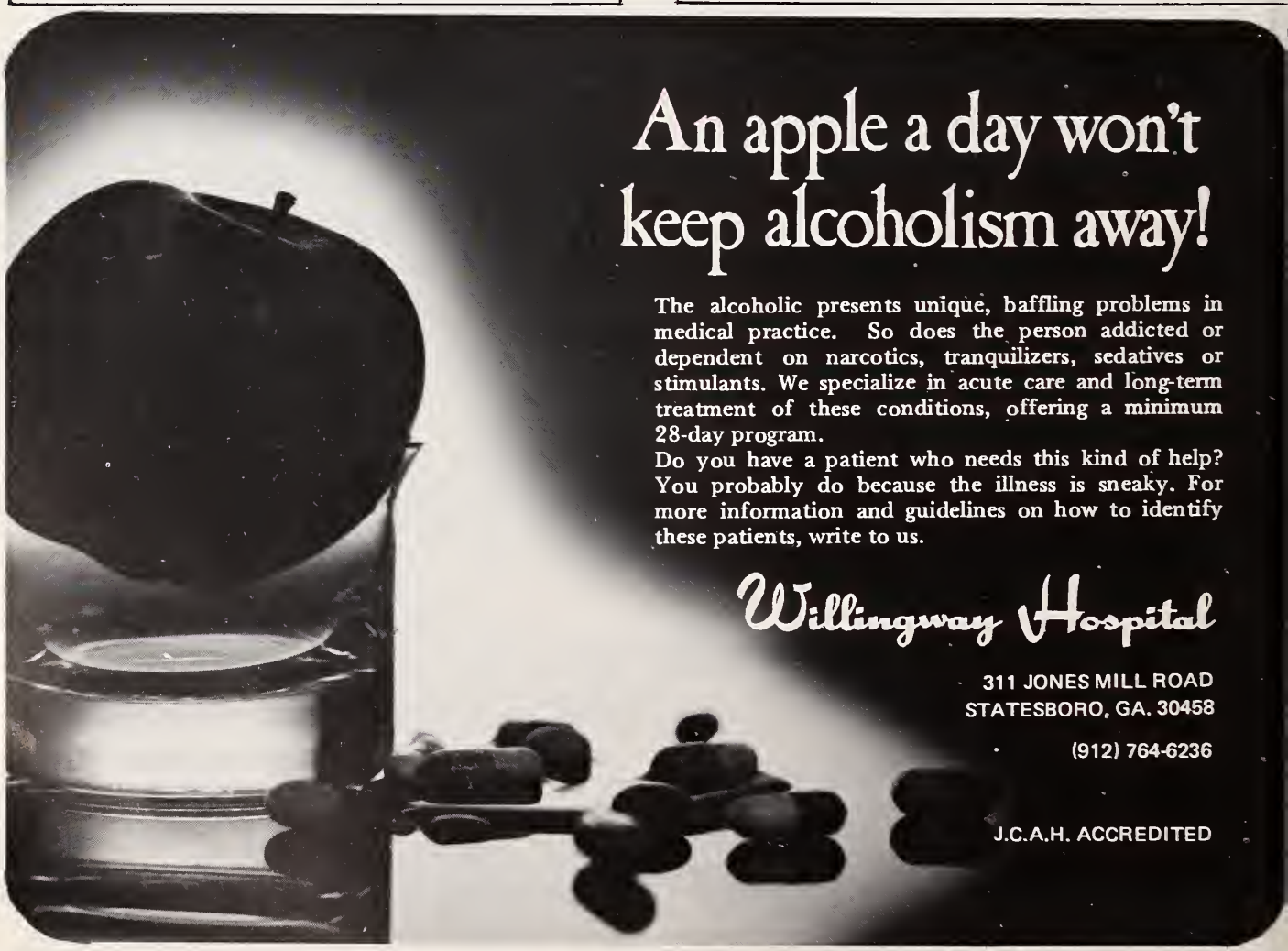
NUTRITION SERVICES CENTER

NUTRITION · SERVICES · CENTER
Emory University
SCHOOL OF MEDICINE

PHYSICIAN REFERRAL

- Computerized Nutrition Analysis
- Diet Therapy by Clinical Nutrition Specialists
- Hospital Consults

Nutrition Services Center
Emory University School of Medicine
1712 Clifton Road
Atlanta, Georgia 30329
Telephone (404) 329-5737



The Round-Peg, Square-Hole Syndrome

Health care is no longer a social, ethical, or moral issue. It is a political issue that has been and will continue to be, maintained in the central vision of the eyes of the public. Understandably, it would be of great value to politicians if they could indicate to the public that they could legislate the best health care to the most people at little or no cost. By promoting the visibility of the problems of the health care industry, the legislators have generated a constant barrage of consumer scrutiny and criticism. This, in turn, has led to a "compliance syndrome" among health care professionals. Physicians, in particular, have become willing to do almost anything if faced with the possible alternative that the federal government, the Joint Commission or someone else, will do it for them or to them.

Such was, and continues to be, the case with Continuing Medical Education (CME).

CME was seized upon by the legislators as *the* means by which they could guarantee to the public that they were outlawing physician abuses and were legislating against intellectual obsolescence. In many states, they succeeded in legislating mandatory CME requirements for re-licensure. The legislators were particularly fond of the CME route. They realized that prosecuting the individual incompetent physician was extraordinarily expensive and time consuming. It was cheaper and more satisfying to force the profession to subsidize it own costs by complying with the legislated lists of criteria that were to be equated with competence. Self-directed, undocumented studies, such as reading and consultations, were no longer acceptable. Only certified hours accumulated by attending courses organized by others would do.

The more critical components in determining true competence – character, integrity, and environmental forces – cannot be measured by CME or the accumulation of knowledge.

The Joint Commission, under pressure from the Department of Health and Human Services (DHHS) (formerly DHEW), also accepted CME as a panacea. Their approach was somewhat more lateral. They promoted the concept of "PCE → CME" (patient care evaluation leading to continuing medical education) as the basis for improving the quality of care. They required that medical staff bylaws include a statement necessitating the documentation of involvement with CME as a prerequisite for reappointment to the staff.

Predictably, with pressure from both sides, the profession, not only complied, but mandated CME for themselves. They made it a requirement in their own specialty societies and medical societies, to prevent the state, federal government, or the Joint Commission from mandating it further. All of this mandating was based on the postulate that the monitoring and remediation of incompetence could be done within the structure of education.

Now that CME has become an annual four billion dollar industry, attention has begun to be directed to whether or not there is any justification in the assumption that there is a relationship between competence and CME.

In 1979, the Alliance on Continuing Medical Education took a major step against the growing tide of mandatory CME requirements that were being used as competence equivalents, and proposed that there be a moratorium on the use of CME credits by state licensing agencies, medical societies, hospital boards, and national specialty societies.

They continued their debate in February, 1980, when the relationship between physician competence and CME was examined in depth. A great deal of time had to be spent in defining "competence." The best composite definition was "a competent physician is one who can, does, and *will* apply the existing state of the science and art of medicine to the optimum level, based on professional standards in the provision of health care, in the context of his or her own practice." Competence, therefore, incorporated the illusive quality of how a physician will behave in the future. While competence itself could not be measured, it was possible to assess some of its components. What could be monitored was performance. Other components which could be evaluated were knowledge, data gathering skills, communication skills and technical skills. The most critical components in determining true competence, however, could not be measured: character, integrity, and environmental forces.

Because there is a relationship between competence and CME it does not mean that one exists between incompetence and CME.

Having just concluded that performance and other components of competence could be assessed, it was also immediately concluded that it was definitely not the role of education to do so. This was the responsibility of "Quality Assurance" and other agencies of the profession, but not education.

Having agreed that it is not the responsibility of education to monitor incompetence, was it realistic to believe that education could correct incompetence?

There *is* a relationship between competence and CME. Education is the main tool for maintaining the knowledge component of competence. CME is desirable, critical, and absolutely indispensable in keeping the competent physician competent. But because there is a relationship between competence and CME does not mean that there is any relationship between incompetence and CME. Education cannot be looked upon as the mechanism for changing the unacceptable behavior of the incompetent physician. While education can affect knowledge, it cannot do anything for integrity, judgment, or character.

It was concluded that neither society represented through any of its organizations (state licensing boards) nor organized medicine represented through any of its organizations (state or county medical societies, specialty societies), should seek to solve the problems of unacceptable medical practice through the use of CME. The ultimate absurdity that must be dispelled is that competence can be equated in any way with the accumulation of a long list of CME credits. Competence cannot be assumed because of the presence of such a list. Likewise, the absence of CME credits does not indicate incompetence.

In the last analysis, the identification and management of the incompetent physician may well reside within the profession itself. We may currently have some of the means for identifying and dealing with the incompetent physician. It just does not reside within the domain or structure of education. The time, energy, and money spent on stuffing a round peg into a square hole has been excessive and exorbitant. It is time that these resources be more appropriately directed.

Carl L. Rosengart, M.D.
Director of Medical Education
Memorial Medical Center, Savannah,
and a member of MAG's Education Committee

Smoke-Free Hospitals—The Time Has Arrived

Sixteen years have elapsed since the first report on the effects of smoking by the Surgeon General of the United States. Each subsequent report has expanded our knowledge of the population at risk and the organ systems affected by tobacco smoke. Physicians have responded significantly in their own personal habits. The American Cancer Society noted that from 1959 to 1972 the percentage of physicians who smoked was reduced by roughly half (from 38.6% to 19.5%). More and more doctors seek to make their offices smoke-free. The AMA, MAG, DeKalb Medical Society, Medical Association of Atlanta, and numerous other local and state medical societies have made it a matter of policy to attempt to eliminate smoking at official functions and to encourage physicians to do the same in their individual practices. Paradoxically, there remains one medical bastion where smoking practices continue virtually unchanged. Our hospitals generally continue to make tobacco products easily available and do little to discourage their consumption.

A few institutions have taken some tentative steps. They have removed cigarette vending machines and declared certain limited areas off-limits for smoking. Several psychiatric facilities in Atlanta have attempted to eliminate smoking on the Adolescent Services (for some reason they seem to think it is O.K. for the older folks), and a few institutions have even offered Stop Smoking Clinics to their employees. Sometimes the situation can be almost schizophrenic. Recently I was called in consultation to see a patient who had a suspected myocardial infarct. As I was interviewing the family, I noticed a number of pamphlets directed at prevention of heart disease, including material urging cessation of smoking, but when I walked into the patient's room, he was puffing away, and his ashtrays were full of cigarette stubs.

If cigarette smoking is indeed unhealthy and leads to or is implicated in a number of disease processes, and there is an overwhelming consensus among physicians regarding this fact, why are the institutions devoted to health such "hotbeds" of cigarette smoking? Although the answers are manifold, I will attempt to give what seem to be some of the significant factors. Smoking is so common and has been such an accepted part of everyday life that we give it little more attention than we devote to the color of the bricks chosen for the exterior of the hospital or the location of water fountains in the corridors. It should be noted that it is precisely things which are so commonplace and ubiquitous which are slower to change than those which are rare and dramatic.

One often hears economic arguments advanced for the continuation of smoking, i.e., some activity of the hospital or the hospital's medical auxiliary is dependent upon the receipts from tobacco sales. Perhaps this is so, but I have yet to see any economic data which indicate that any health-related activity of any hospital would significantly suffer if there were no receipts from tobacco sales. If one were to use this economic argument rationally, a very good position could be made for installing bars throughout every hospital, since the profit from the sale of mixed drinks is quite lucrative and certainly would be a substantial supplement to any hospital's budget. As a matter of fact, from a strictly economic standpoint, it is quite possible that an institution which certified that it maintained a NO SMOKING policy might well receive a substantial reduction in its fire insurance premium.

An issue frequently cited is that of "limiting freedom." This is a specious one, since the intent is not to tell people that they should or should not engage in a particular act, smoking, but simply to define the limits of what is acceptable within the particular institution. As noted above, hospitals make no attempt to tell people that they should or should not consume alcoholic beverages, but they are not in the business of selling alcohol, and it is implicit that hospitals are not a site for alcohol consumption.

What about fears that patients will not use an institution in which tobacco

products are not allowed and will seek out a competitive establishment? First of all, we all know that extensive competition does not exist and, secondly, the experience of Atlanta department stores is quite salutory. Most department stores and, interestingly, those which cater to the most wealthy and therefore possibly the most fickle clientele, have firm NO SMOKING policies which are observed quite well. In other words, even heavy smokers have come to accept the fact that there are certain public facilities in which smoking is not allowed.

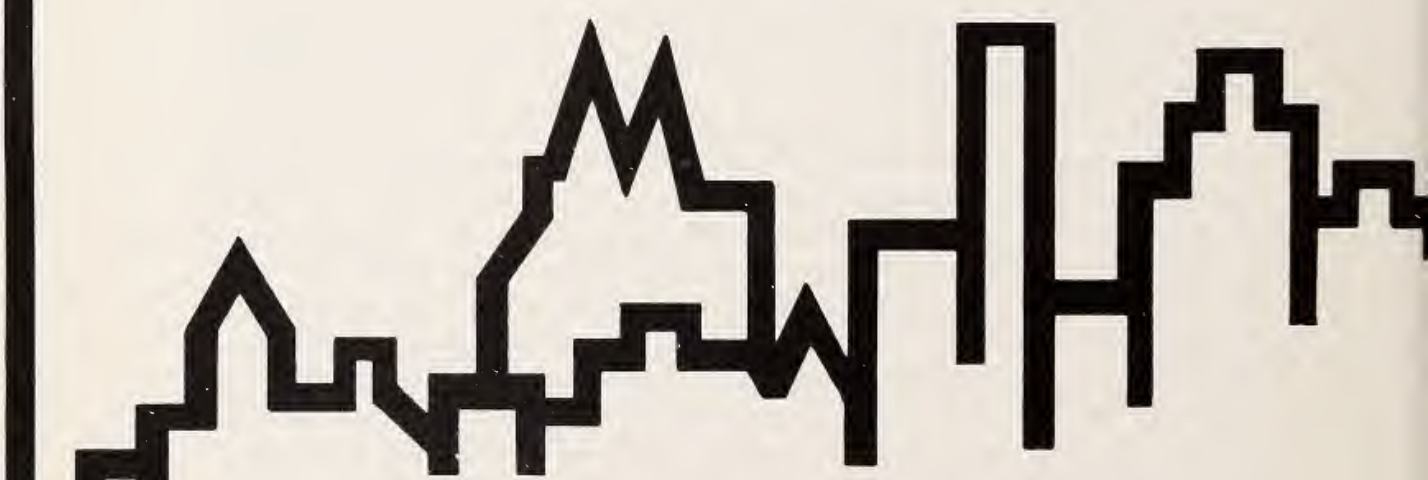
What should we do? It would seem incumbent on the medical staff of every hospital, nursing home, or other medical facility to examine the issue thoroughly and decide if there are compelling medical reasons for allowing tobacco smoking in their institutions. If not, the staff should strongly recommend to the governing board of the facility that all tobacco smoking be eliminated as soon as possible. If circumstances allow, this may be done de facto overnight. Otherwise, vending machines should be removed at once, a deadline for implementation should be set up, and an appropriate educational and informational program should be developed for hospital personnel, families, visitors, and patients. The hospital administrator should be instructed to contact the agent handling fire insurance to determine whether lowered rates can be obtained if smoking is not permitted in the building.

The medical profession is sometimes criticized for not doing things that promote good health. Here is a splendid opportunity for us to take simple, sensible action.

Sheldon B. Cohen, M.D.
401 Peachtree St. N.E., Ste. 804
Atlanta, GA 30308

Psychiatric Institute of Atlanta

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

heart page
heart page
heart page

Transluminal Coronary Angioplasty

ARNOLDO FIEDOTIN, M.D., *Atlanta**

In 1964, Dotter and Judkins began to relieve atheromatous obstructions in peripheral arteries with the help of special catheters in an attempt to avoid surgical intervention. Initially, Dr. Dotter used catheters of progressively larger diameter, advanced one after the other, but eventually switched to a double lumen catheter with a distal balloon advanced through a guide wire into the stenosis, with the lesion being compressed laterally by inflation of the balloon. This was performed percutaneously under local anesthesia with a great deal of success and safety. Angiographic studies performed at varying intervals after angioplasty showed the dilated areas to remain patent. Although Dr. Dotter did not have many followers in America, his work was accepted throughout Europe, where his technique for peripheral artery disease was widely used. Dr. Gruntzig in Zurich adapted that approach and modified it for coronary artery disease by the use of a special catheter of his own design. In 1976 he began work with dogs and shortly thereafter with cadavers. In 1977, he and his associates began to use transluminal coronary angioplasty during coronary artery bypass graft surgery and found that the procedure could be utilized without producing peripheral emboli of atheromatous material. Accordingly, in September, 1977, the first patient underwent percutaneous transluminal coronary angioplasty by Dr. Gruntzig. Following the initial success in Switzerland, Dr. Kaltenbach dilated the first patient in Germany in November, 1977. Drs. Myler in San Francisco and Stertzer in New York operated on the first American patients in March, 1978, after which the technique was followed with a great deal of interest in America.

It consists of introducing a specially made double lumen catheter with a balloon of 3 or 3.7 mm. diameter in its distal segment, with the balloon being of 12 or 20 mm. length, and with a distal port beyond the balloon for injection of contrast material and pressure monitoring. The distal end of the Gruntzig catheter has a very small, highly flexible guide wire to help its advance. The catheter is very small, has no torque control, and must be introduced through the inside of a larger, "guiding" catheter. The guiding catheter is preshaped to engage the ostia of either right or left coronary arteries, and under pressure monitoring in both catheters, the dilating catheter is advanced into the coronary artery that is obstructed.

Transluminal coronary angioplasty is presently performed following a protocol designed by Gruntzig that will permit the evaluation of the results of this technique. All patients must be symptomatic and undergo a complete history and physical examination with emphasis on evaluation for risk factors. Before angioplasty they undergo stress testing and myocardial scanning with thallium at rest and during exercise. Following angioplasty, the patients are followed by serial ECG's and

* Dr. Fiedotin practices cardiology. His address is the Atlanta Cardiology Group, P.C., 5665 Peachtree-Dunwoody Rd., NE, Atlanta, GA 30342. Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

enzyme determinations, and repeat stress test and thallium scan are obtained 2 days after the procedure. Two months later, they have another stress testing, and 6 months following TCA a repeat cardiac catheterization is done, to determine the long-term patency of the bypass. The patients are treated with beta blockers, nitrites, and aspirin before the day of the procedure, and receive low molecular weight dextran intravenously in addition to heparin, several nitroglycerin tablets, and 20 mg. Nifedipine during the dilatation. Afterwards, they continue with aspirin and nitrites and beta blockers if necessary. Following successful transluminal angioplasty, there is a reduction in the pressure gradient across the stenosis, which is measured through the distal port of the balloon catheter. Gruntzig has shown a definite decrease in the severity of the stenosis, linearly related to the decrease in pressure gradient.

The technique is not uniformly successful because of different problems such as: (1) Inability to advance the guiding catheter into the aortic root due to peripheral vascular disease; (2) Inability to engage the coronary ostium with the guiding catheter; (3) Inability to advance the Gruntzig catheter into the proper vessel; (4) Not being able to pass the lesion with the Gruntzig catheter; (5) Inability to dilate the lesion; and (6) Complications.

To date, there has been one death directly related to the procedure, although not to the dilatation itself. There have been three delayed deaths following dilatation of main left coronary artery lesions (e.g. 2 and 9 months after PTCA). Main left coronary arteries, therefore, are not being considered for angioplasty at the present time. Impending or definite infarctions have also resulted, usually due to dissection of the atheromatous plaque by the catheter.

Because of the possibility of complications during the procedure, it is presently performed only with surgical standby, with not only a surgeon but also an anesthesiologist, operating room, and pump oxygenator readily available to perform emergency surgery should any problems occur.

The results have been rather encouraging, with improvement noted not only symptomatically, but also in the stress test, thallium scan, and post-dilatation angiography.

The degree of success increases with the experience of the operator, and at the present time 90% of the patients who were successfully dilated initially have shown persistently patent arteries when followed up at an average of 6 months (up to 24 months followup at present).

In summary, currently transluminal coronary angioplasty is indicated for lesions which are: proximal, concentric, discrete, subtotal, and non-calcific. The patient must be a candidate for coronary artery bypass graft, and patients who are prone or known to have coronary spasm are not considered for this procedure.

A General Surgeon Looks at Breast Reconstruction

CHARLES R. UNDERWOOD, M.D., *Marietta**

In the past 5 to 10 years, we have seen the standard treatment of breast malignancy change from the extended operations, such as the radical mastectomy, to the more limited procedures, such as the local excision and modified radical procedures. Moreover, there is good statistical proof that the control and cure of the disease has not diminished.

These comments, then, bring me to what I consider a rather crucial problem at the present time . . . namely the approach to the problem of reconstruction of the chest wall and the breast following surgical management of the disease. There has been a rather aggressive move in this area, as evidenced by such organizations as "AFTER" which is directed toward the encouragement of the post-mastectomy patient to proceed with reconstruction.

As physicians, we have had to evaluate this surgically available approach to the management of the post-mastectomy patient with a view toward what it can and cannot accomplish. It should first be realized that (1) breast reconstruction has been done for a number of years; (2) it has been developed into a highly refined art and science by a few interested individuals in the country, and (3) is now available from many plastic surgeons. It is usually very expensive, more so than other surgical procedures. It should not be done on all post-mastectomy patients for a variety of good medical reasons. Just as the primary management of cancer of the breast should be a team effort involving all those individuals who provide different facets of this management, so should the approach to breast reconstruction be a "team effort," involving not only the plastic surgeon who will be performing the actual reconstruction but also the general surgeon, the radiologist, and the oncologist who should advise about the procedure.

My answers to some basic questions are:

Is breast reconstruction a good operation? Yes, when done by qualified surgeons on the appropriate patient.

Should everyone who has had a mastectomy have breast reconstruction? No, because many factors enter into the decision to do the reconstruction beyond the simple desire of the patient to have it done.

Should a second opinion be obtained regarding the need for breast reconstruction? Yes, for it should be a team effort with input from the plastic surgeon, the primary surgeon who did the mastectomy, other individuals concerned with the treatment of the patient, and possibly even another reconstruction surgeon.

* Dr. Underwood is a general surgeon. His address is 641 Church St., Marietta, GA 30060. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

Index to Advertising

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

Vol. 69 August 1980 No. 8

Ballard, Walter, Optical Company 728
Boehringer-Ingelheim, Ltd. 708-710
Brawner Psychiatric Institute 652
Classifieds 728
The Coca-Cola Company 703
Decatur Hearing Aid Service 727
The Devereux Foundation 714
Dickey-Mangham Company 702
Electric Research Corporation 655
Fulton Federal Savings and Loan Association 702
Gatsby, J., and Company 678
Global Imports 701
The Great Cherokee Trading Company 728
Hickman-Datsun 702
Insurance Corporation of America 671
JMAG Classifieds 651
Lilly, Eli, and Company 677
Merrell-National, Inc. 706, 707
Metro Ambulance 675
Nutrition Services Center 718
Ortega Pharmaceutical Company, Inc. 654
Peachtree and Parkwood Mental Health Center and Hospitals 676
Potter-Holden and Company 718
Psychiatric Institute of Atlanta 722
Ridgeview Institute 672
Roche Laboratories 650, 651, 729, 730
The Rocker Shop 727
Valley Psychiatric Hospital 716
Weight Watchers of Greater Atlanta 727
Willingway Hospital 718
Wyeth Laboratories 661, 662

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976:294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,
Anne & Harry Friedman
Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
© WEIGHT WATCHERS INTERNATIONAL, 1977

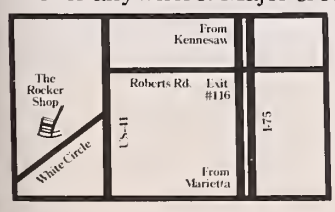
ROCKING THE NATION FOR OVER 100 YEARS...THE ONE AND ONLY BRUMBY ROCKER, ONLY AT THE ROCKER SHOP.

Few things have withstood the test of time as the Brumby Rocker. From it's early southern heritage, to today's White House, the Brumby has established a reputation as the world's finest handcrafted rocker. The moment production begins, to the moment we sell it to you, the Brumby is treated with the finest skill and care. The same skill and care used over 100 years ago when Brumbys were first made in 1875.

A Brumby Rocker is an investment in a future family heirloom. In fine homes throughout the country it has become a part of the family, rocking generations of children and a source of relaxation for all.

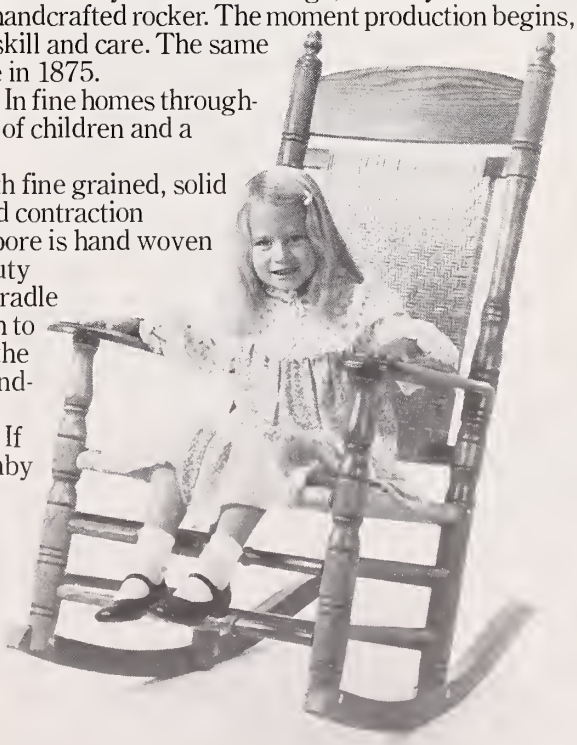
What gives the Brumby this enduring popularity? It begins with fine grained, solid oak which is half air dried and half kiln dried for natural expansion and contraction which helps prevent warping or bending. "Blue Tie" cane from Singapore is hand woven on both sides of the seat and back for comfortable cushioning and beauty from every angle. The steam bent back posts are curved to naturally cradle your back. The extra wide runners are designed with a slight rear arch to give an even rock and help prevent tipping. The man-size arms, with the original Brumby seal, let you rest your elbows comfortably. All are hand-sanded to a warm finish that accentuates the fine grained wood.

Good things are hard to find, but always well worth the search. If the Rocker Shop is a little out of your way, we'll gladly ship your Brumby Rocker anywhere. Major credit cards accepted.



The Rocker Shop of Marietta, Georgia

1421 White Circle, N.W. • P.O. Box 12
Marietta, Georgia 30061 • (104) 427-2618



Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$10.00 for the first 25 words; $.25 per word for each additional word. **Non-members**—$20.00 for the first 25 words; $.25 per word for each additional word. *Charges are payable in advance*. Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535. INWATS in Georgia (800) 282-0224.

SITUATION WANTED

Psychiatrist desires association in a group or clinic or purchase of an active practice. Available by August-September 1980. Please write to Box 7-A, c/o the *Journal*.

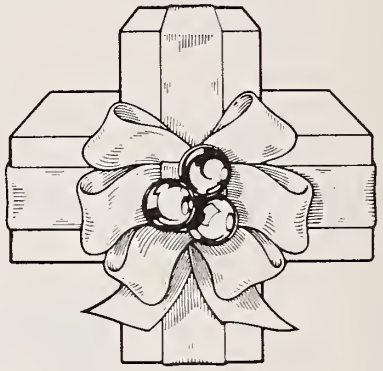
PHYSICIAN WANTED

Solo OB-GYN practitioner needs associate in his practice located in Decatur. Please respond to Box 8-A, c/o the *Journal*, 938 Peachtree St., NE, Atlanta 30309.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call (404) 634-1234.

GIVE SOMEONE A GIFT THEY CAN'T LIVE WITHOUT.



American Red Cross

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

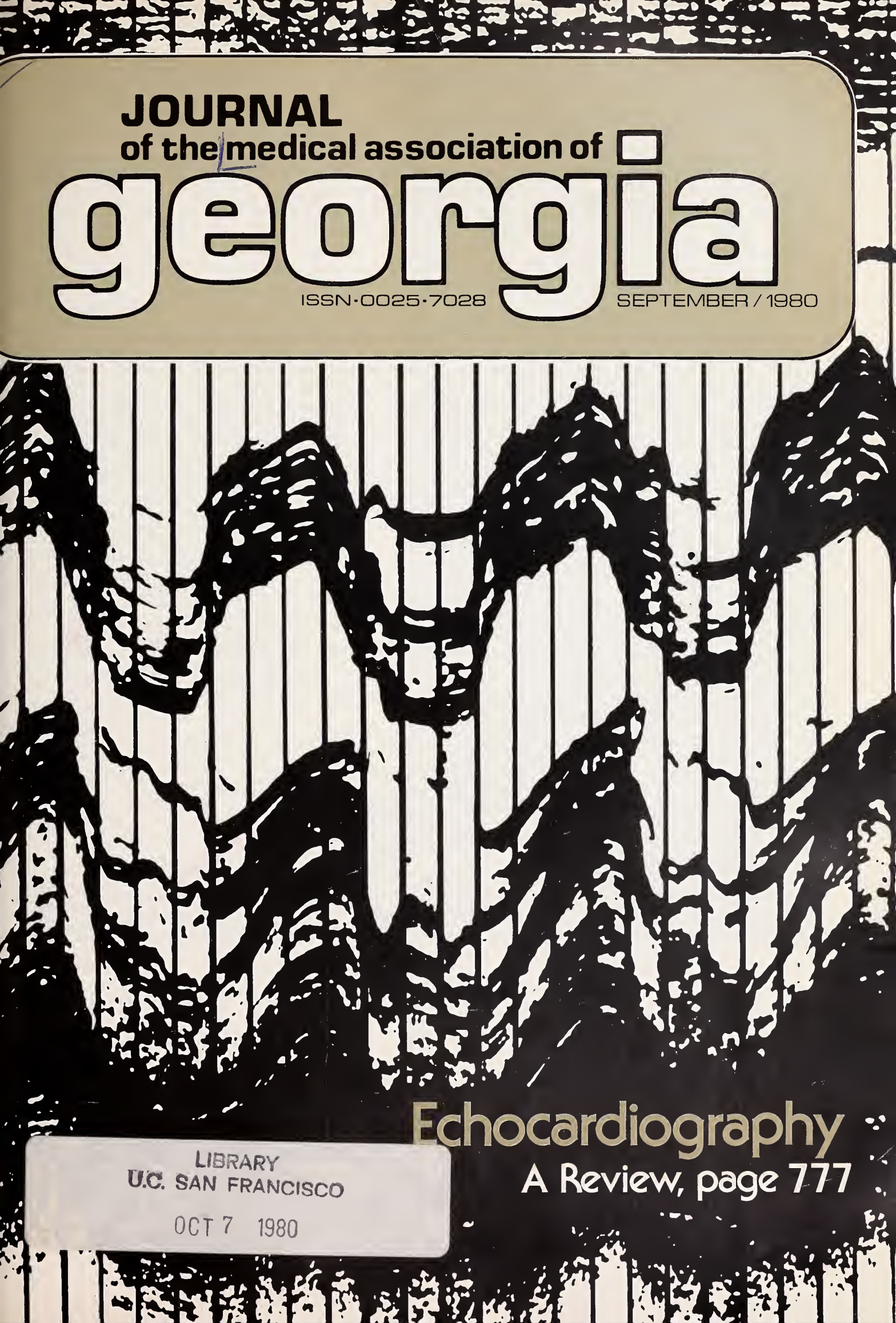
Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

JOURNAL
of the medical association of
georgia
ISSN·0025·7028 SEPTEMBER / 1980



Echocardiography
A Review, page 777

LIBRARY
U.C. SAN FRANCISCO
OCT 7 1980

half-life

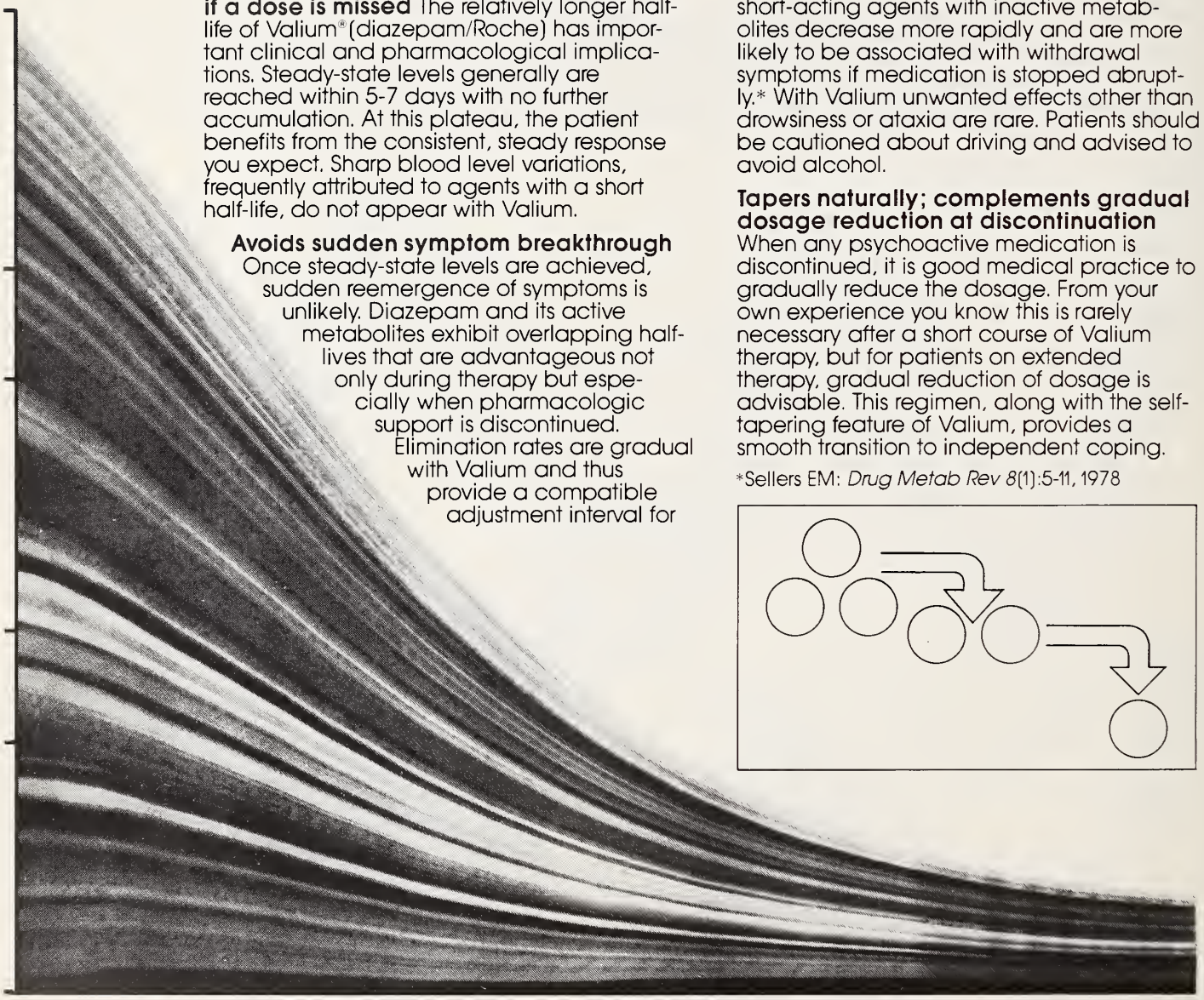
Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



in the management of symptoms of anxiety

Valium®(IV)
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page.

ROCHE®

Valium®(V)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



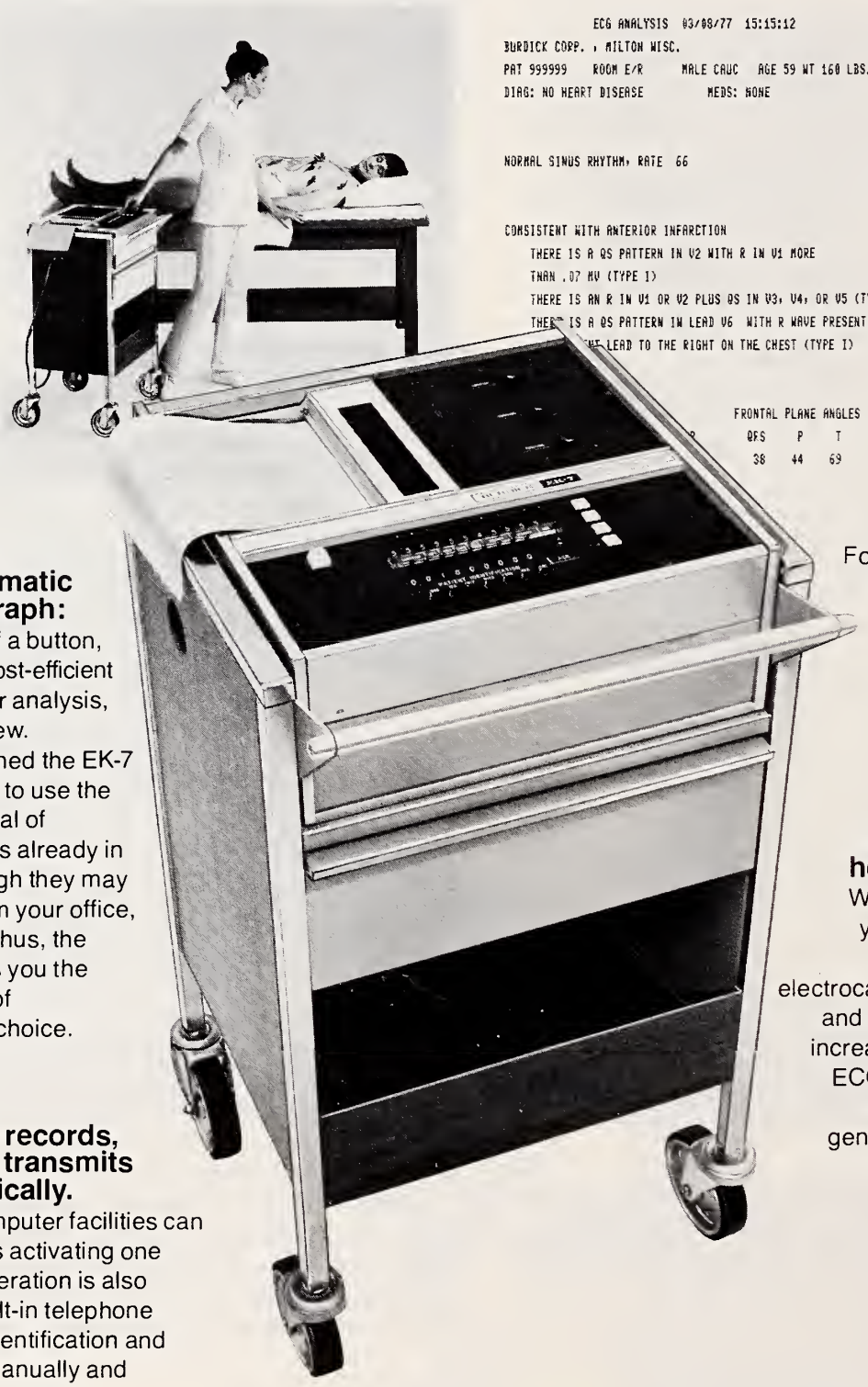
Lung cancer is now an equal opportunity tragedy.

Remember when lung cancer was a man's disease. Because men had been smoking longer than women. But the women's smoking boom that started in the 1930's and 40's—is paying most cruel dividends today. Yet most people still think lung cancer is a man's disease. Tell your female patients the true story. That lung cancer is now an equal opportunity tragedy. That's what "you've come a long way, baby" is all about.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office on Smoking and Health
Public Health Service Rockville, MD 28057

Burdick's new EK-7:

Today's intelligent answer for computerized ECGs.



Burdick's new 3-channel automatic electrocardiograph:

At the touch of a button, the EK-7 provides cost-efficient ECGs for computer analysis, ready for your review.

Burdick designed the EK-7 acquisition system to use the interpretive potential of computer programs already in service, even though they may be many miles from your office, clinic or hospital. Thus, the Burdick EK-7 gives you the greatest freedom of computer-service choice.

Burdick's EK-7 records, translates, and transmits ECGs automatically.

Access to computer facilities can be as automatic as activating one button. Manual operation is also possible with a built-in telephone handset. Patient identification and statistics are set manually and transmitted automatically.

For immediate examinatio you get scratch-resistan smudge-free tracing produced on Burdick easy-to-read BlueTrac 3-channel pape

Burdick an computer-assiste electrocardiograph help meet your need

When you invest in an EK- you invest in your practice Computer-assiste electrocardiography substantiate and augments your diagnosi increases speed and volume ECGs administered. For yo review, you get compute generated ECG interpretatio in minute

Electric Research Corporation

1399 DUTCH VALLEY PLACE, N.E. • TELEPHONE 873-1084
ATLANTA, GEORGIA 30324

JOURNAL
of the medical association of georgia

contents

VOLUME 69, NUMBER 9

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director
Joyce Butler, R.N., Assistant Executive Director
J. Tom Sawyer, Assistant Executive Director
Kenneth M. Williams, Director of Public and Professional Relations
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

745 Therapy of Hypertension: 1980
W. Dallas Hall, M.D.
755 Squamous Cell Carcinoma of the Thyroid Gland
Jeffrey R. Lee, M.D.
M. Darius Vohman, M.D.
William J. Pendergrast, M.D., F.A.C.S.
759 Association of Chronic Pancreatitis and Alcoholic Cirrhosis
Hans W. Adams, M.D.
Paul D. Webster, III, M.D.
David L. Mainz, M.D.
765 A Pilot Study of Early Ischemic Lesions in the Myocardium
Mehboob Fatteh, M.D.
769 Delayed Diazepam Withdrawal Syndrome: A Case of Auditory and Visual Hallucinations and Seizures
Deen Bandhu Chandora, M.D.

SPECIAL ARTICLE

749 Heat Wave Related Mortality — United States Center for Disease Control

EDITORIAL

780 On Medical Ethics
F. Edward Payne, Jr., M.D.

FEATURES

777 Heart Page/ Echocardiography — Its Usefulness and Limitations
Miltiadis A. Stefadouros, M.D.
785 Legal Page/Recent Developments in the Health Care Area
Thomas D. Harper
Robert N. Berg

THE ASSOCIATION

788 The President's Letter/A Beautiful Partnership
H. Hilt Hammett, Jr., M.D.
789 New Members
789 Personals
790 Societies
790 Deaths
791 Physician's Recognition Award Recipients

INCIDENTAL INTELLIGENCE

736 Medical Meeting Calendar
743 Georgia's Newborn Screening Program
743 Argon Laser Treatment for Superficial Vascular Lesions
744 Georgia Heart Association Plans Nurse Conferences in Eight Georgia Cities

COVER

Echogardiogram courtesy of Emory University School of Medicine. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

MEDICAL MEETING CALENDAR

SEPTEMBER

18-20—*Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Category 1 credit; Contact: William C. McGarity, MD, Secy.-Treas., Georgia Surgical Society, 1365 Clifton Rd., NE, Atlanta 30322.

22-24—*Augusta;* **CRITICAL CARE SYMPOSIUM;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

25-27—*Williamsburg, VA;* **MODERN APPROACH TO ACUTE CORONARY CARE;** Category 1 credit; Contact: Tidewater Chapter, American Heart Association, 891 Norfolk Square, Norfolk, VA 23502. PH: 804/857-5961.

26-27—*Las Vegas, NV;* **EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800-525-8646.

26-27—*Atlanta;* **ANNUAL MEETING AND SCIENTIFIC SESSIONS, AMERICAN HEART ASSOCIATION, GEORGIA AFFILIATE;** Category 1 credit; Contact: Ann Angelo, American Heart Association, Georgia Affiliate, 2581 Piedmont Rd., NE, Broadview Plaza, Level "C", Atlanta 30324. PH: 404/261-2260.

27-30—*Kansas City, MO;* **CLINICAL DRUG THERAPIES** (AMA); Category 1 credit; Contact: Frank Chappell, AMA. PH: 312/751-6606 (Office) or 312/644-2426 (Home).

OCTOBER

1—*Savannah;* **MANAGING PEOPLE AND MONEY IN YOUR PRACTICE;** AMA faculty; Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 1-800-282-0224.

1—*Savannah;* **MEDICAL COLLECTION MANAGEMENT;** AMA faculty; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 1-800-282-0224.

2—*Augusta;* **MANAGING PEOPLE AND MONEY IN YOUR PRACTICE;** AMA faculty; Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 1-800-282-0224.

2—*Augusta;* **MEDICAL COLLECTION MANAGEMENT;** AMA faculty; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 1-800-282-0224.

3-5—*Callaway Gardens;* **10th ANNUAL MEETING, GEORGIA GASTROENTEROLOGIC SOCIETY;** Contact: Harold Asher, MD, 340 Boulevard, NE, Atlanta 30312.

3-5—*Callaway Gardens;* **2nd ANNUAL MEETING, GEORGIA SOCIETY FOR GASTROINTESTINAL ENDOSCOPY;** Contact: W. Scott Brooks, MD, 1365 Clifton Rd., NE, Atlanta 30322.

4-5—*Big Canoe;* **CLOSING YOUR PRACTICE;** AMA faculty; Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 1-800-282-0224.

4-9—*New Orleans, LA;* **1980 ANNUAL AMERICAN ACADEMY OF FAMILY PHYSICIANS SCIENTIFIC ASSEMBLY AND CONVENTION/WONCA NINTH WORLD CONFERENCE;** Category 1 credit; Contact: Beth Robertson, American Academy of Family Physicians, 1740 West 92nd St., Kansas City, MO 64114. PH: 800-821-2512.

9-10—*Atlanta;* **THE PAIN-DISABLED PATIENT;** Contact: Ronald G. Havican, Center for Rehabilitation Medicine, Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5507.

10—*Atlanta;* **EIGHTH ANNUAL CARDIAC SYMPOSIUM;** Contact: Gerald F. Fletcher, MD, Dir. of Internal Medicine, Georgia Baptist Medical Center, 300 Boulevard, NE, Atlanta 30312. PH: 404/659-4211.

19-24—*Atlanta;* **66th ANNUAL CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS;** Category 1 credit; Contact: Dianne Currie O'Rourke, Mgr. of Public Information, American College of Surgeons, 55 East Erie St., Chicago, IL 60611.

24-26—*Atlanta;* **CLINICAL MANAGEMENT OF CORONARY DISEASE AND EXERCISE TESTING;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800-525-8646.

25-30—*Detroit, MI;* **AMERICAN ACADEMY OF PEDIATRICS 50TH ANNIVERSARY MEETING;** Category 1 credit; Contact: Joanna Hague, P.O. Box 1034, 1801 Hinman Ave., Evanston, IL 60204. PH: 312/869-4255.

26-30—*Boston, MA;* **46th ANNUAL SCIENTIFIC ASSEMBLY OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS;** Category 1 credit; Contact: Mary Ellen Pictor, Press Relations Coordinator, American College of Chest Physicians; 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

31-Nov. 2—*Callaway Gardens;* **PHYSICIAN PLACEMENT SEMINAR;** Contact: Joyce Butler, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta 30309, PH: 404/876-7535.

NOVEMBER

6-9—*Atlanta;* **32nd ANNUAL GEORGIA ACADEMY OF FAMILY PHYSICIANS SCIENTIFIC MEETING;** Category 1 credit; Contact: Camille Day, Georgia Academy of Family Physicians, 11 Corporate Square, Suite 205, Atlanta 30309. PH: 404/321-7445.

14-16—*Sea Island;* **PRIMARY CARE OF HAND INJURIES;** Contact: American Society for Surgery of the Hand, 2600 South Parker Rd., Suite 132, Aurora, CO 80014. PH: 303/755-4588.

15-16—*Albany;* **1980 GEORGIA ASSOCIATION OF EMERGENCY MEDICAL SERVICES CONFERENCE;** Contact: C. B. Gillespie, MD, Course Director, 810 14th Ave., Albany 31701. PH: 912/435-1458.

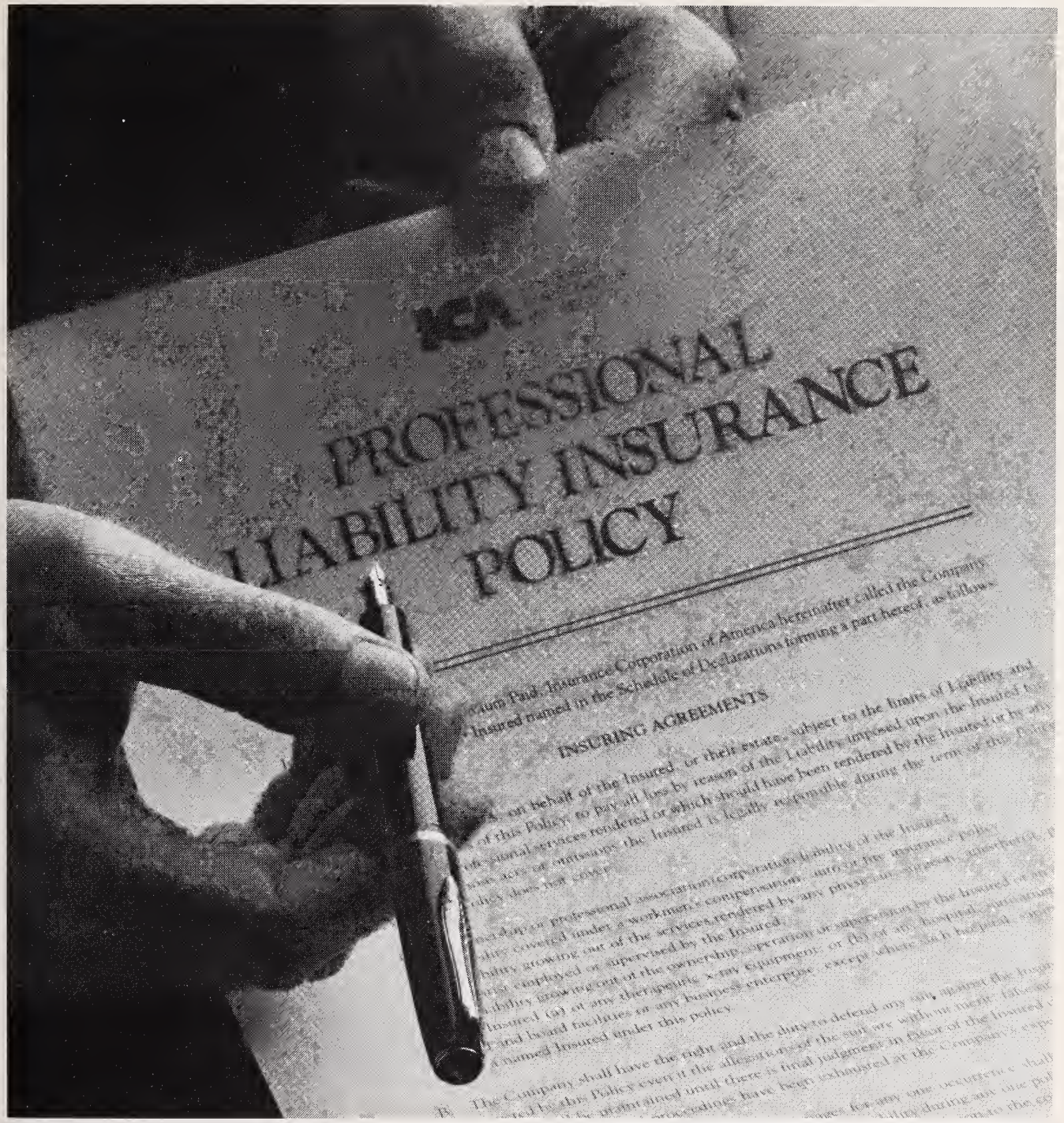
16-19—*San Antonio, TX;* **SOUTHERN MEDICAL ASSOCIATION'S 74th ANNUAL SCIENTIFIC ASSEMBLY;** Contact: Southern Medical Association, 2601 Highland Ave., Birmingham, AL 35205. PH: 205/323-4400.

16-21—*Dallas, TX;* **RSNA 66th SCIENTIFIC ASSEMBLY AND ANNUAL MEETING;** Contact: Radiological Society of North America, 1415 West 22nd St., Suite 1150, Oak Brook, IL 60521. PH: 312/920-2680.

21-23—*Atlanta;* **1980 MAG SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (toll free in Georgia).

DECEMBER

3-7—*Atlanta;* **5th SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE;** Contact: Mary Galos, Peachford Hospital, 2151 Peachford Rd., Atlanta 30338. PH: 404/455-3200, Ext. 550.



PUT A CONTRACT OUT ON FRIVOLOUS CLAIMS.

Frivolous claims can be a nightmare. Especially if your malpractice insurance company doesn't stand by you. And unfortunately, all too many don't.

For instance, most malpractice insurance policies give you no say in whether to fight or settle a claim. And if you do have a say, you can be hit with a costly penalty for going to court. Another thing. Many companies don't pay all legal expenses. And most companies seldom use lawyers to process cases. Claims are often handled only by claims adjusters.

It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working for doctors. So we know the strong coverage and knowledgeable service physicians need from their liability insurance. And since we specialize in this one field, we can offer a superior policy for a realistic premium. Premiums based on actual costs in your state.

So select the policy with the protection you need. Put a contract out on frivolous claims. For more information contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas Phone 1-800-231-2615

ICA INSURANCE CORPORATION OF AMERICA

MALPRACTICE INSURANCE IS BETTER TODAY. BECAUSE OF ICA.

Peachford Hospita

A uniquely positive, comprehens

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.

CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge.

Twenty-four hour admittance is offered for all programs.





MEDICAL SERVICE DIRECTORS

BOAZ HARRIS, M.D.
Medical Director

CONWAY HUNTER, JR., M.D.
Director, Addictive Disease Unit

CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

JOHN B. HARDMAN, M.D.
Director, Children's Unit

ogram of recovery...that's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

plete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30338
Phone (404) 455-3200





80%*

*80% of the stocks recommended by Robert D.Carl, III, during the past three years have been profitable. More importantly, **95%** of closed positions have been profitable. Mr. Carl, Executive Vice President of J. Gatsby & Co., is solely responsible for all final decisions regarding stocks recommended in **THE NEW CONTRARIAN**, a stock advisor newsletter published twice monthly in Atlanta and advertised nationally in **BARRON'S.** He is also President of Carl Investment Associates, Inc., an investment advisor firm managing portfolios for individuals, corporations, pension funds and trust funds. While it cannot be assumed that future recommendations will be profitable or as profitable as past selections, a copy of Mr. Carl's performance record and **A WORD ABOUT CONTRARY INVESTING** may be obtained by writing J. Gatsby & Co.

THE NEW CONTRARIAN
published by
J. GATSBY & CO.
(registered with the S.E.C.)
is an **exceptional** securities newsletter.

30 DAY
unconditional
100% CASH REFUND GUARANTEE

☐ Enclosed is check for $165 for 1 year subscription.
☐ Enclosed is check for $95 for 6 months subscription
Circulation Dept J Gatsby & Co
1054 First National Bank Building
Decatur Georgia 30030

Name _____
Address _____
City _____ State _____ Zip _____

WHEN ANXIETY AND TENSION MAGNIFY PAIN IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® C IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

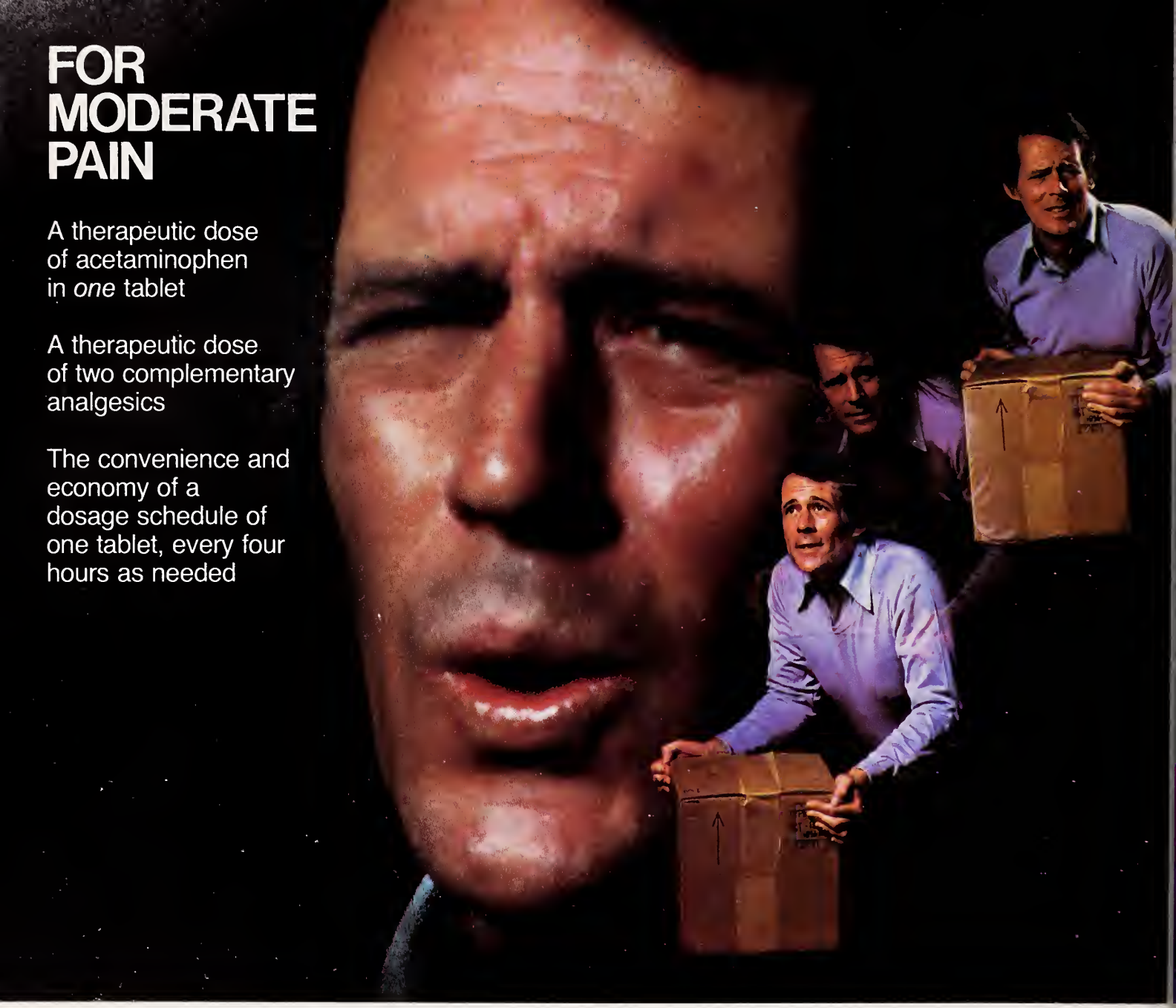
Wyeth Laboratories
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® (IV)

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Wernings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an enticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa. 19101

Incidental Intelligence . . .

Georgia's Newborn Screening Program

The state law (Georgia Law 1978, page 2262) requires that all infants born in Georgia be tested for phenylketonuria, maple syrup urine disease, homocystinuria, tyrosinemia, galactosemia, and hypothyroidism.

The Rules and Regulations require that screening be done by the time the infant is 1 week old, preferably at about 48-hours old, and after having received protein feeding for 24 hours. A blood specimen must be taken on all babies *before discharge*. In addition, those discharged under 48-hours old should have arrangements made to have a repeat test done by 7 days of life. Since brain damage may occur when these diseases are not treated early in life, immediate retesting when indicated by the initial test is necessary in order for the diagnosis to be made soon enough. Either colostrum or breast milk given over a 24-hour period provides an adequate protein challenge, so there need be no delay for testing breast-fed babies.

Screening the newborn for sickle cell (Hemoglobin-S.) is also required by state law. Rules and Regulations were subjected to public hearing in December, 1979, approved by the Georgia Department of Human Resources (DHR), in February, 1980, and became effective April 3, 1980. Updated guidelines revised to reflect procedural changes have been mailed to the hospitals with newborn services, physicians, licensed laboratory directors, and county and district health departments.

Blood from the umbilical cord is the preferred specimen for hemoglobin testing; however, capillary blood can also be used if necessary. The blood should be collected at the time of the infant's delivery and sent to one of the four state laboratories (see attachment G and H of Guidelines) or any other properly licensed laboratory for testing. All infants are to be tested, since electrophoresis will identify a number of other abnormal hemoglobins, in addition to Hemoglobin-S.

The Sickle Cell Center, Medical College of Georgia, will do comprehensive reference testing on all the abnormal specimens detected by the screening laboratories and this service requires about 1 month. Copies of all completed reports are sent to the hospital of the infant's birth, the physician noted on the slip sent with specimen, and the health department in the county where the parents reside.

The law requires that the local health departments and/or physicians offer counseling to the parents of a child with sickle cell hemoglobin. A letter of understanding between the DHR and the Sickle Cell Foundation of Georgia, Inc., has been signed. This agreement delegates certain responsibilities to the Foundation. The Foundation serves as a central location for all abnormal hemoglobin test results and works with the family physician and health department personnel to provide follow-up, consultation, and additional services as needed.

By July, 1980, five infants had been diagnosed with phenylketonuria, one with homocystinuria, two with galactosemia, and 29 with primary hypothyroidism. We appreciate the interest shown in these programs and plan to give periodic reports of the progress. Questions and comments should be directed to Lillian Warnick, M.D., 47 Trinity Ave., S.W., Room 364-S, Atlanta, GA 30334; Phone (404) 656-4830, or Eve Blake, Room 116-H, 656-4850.

Argon Laser Treatment for Superficial Vascular Lesions

Piedmont Hospital in Atlanta will soon be opening its new Laser-Treatment Center. This is a facility using the latest laser equipment and scientific knowledge in the treatment of portwine stains, certain other types of hemangiomas, telangiectasias, and tattoos under limited conditions. It will be the only such center in Georgia, and one of five in the Southeast. It will be one of only four or five in the country, with a general anesthetic capability for the treatment of larger lesions. The facility is located in the McDonnell Surgical Center which provides full outpatient surgery facilities. Lovic W. Hobby, M.D., Diplomate of the American Board of Plastic and Reconstructive Surgery, is the Director of the Center. He will be available to all patients with these types of problems for consultation, testing, and treatment.

Portwine stains are congenital anomalies consisting of an abnormal collection of blood vessels present beneath a layer of otherwise normal skin. This network is a vestige of dense vascular tissue that was present during the first month of embryologic life. The hemangioma is present on the skin at birth and appears to grow at the same rate as the surrounding tissues. By the fourth or fifth decade of life it usually becomes thicker or spongier than the adjacent tissue and develops a cobblestone or bubble-like surface.

Throughout medical history, many modalities of treatment have been used in an attempt to improve portwine stains. Dry ice, carbon dioxide, x-ray therapy, tattooing, sclerosing agents, and a multitude of plastic surgery procedures are among the methods used which have failed to produce fully satisfactory results.

The Argon laser presents a unique opportunity for the treatment of such lesions. It is an extremely high energy source for blue-green light which can be finely focused down to a 1 mm in diameter coherent beam. The light passes through the essentially colorless epidermis without effect, but when it strikes the red color of the hemoglobin in the red blood cells packed in the abnormal concentration of small blood vessels, the enormous energy is converted to a heat. The heat coagulates or cauterizes the small vessels. Clinically, there is a burn-like reaction which is transmitted then to the skin from the inside out. This produces a superficial second degree burn to the area which is immediately noticed. The patient cares for this wound in the same fasion that one would treat any superfi-

cial burn. The crust usually separates in 2 to 3 weeks. The redness gradually fades over the next several months. At that point the full effect of the laser treatment can be seen. This point varies with individuals and may range from 3 or 4 months to as much as a year. There may be a slight depression in the area of skin treated, but this usually smoothes out as healing progresses.

It is important to realize that the Argon laser usually does not completely eliminate the portwine stain. There is significant improvement, however, in approximately 70% of those patients treated. Usually patients are able to switch from Covermark makeup to a normal makeup. The laser also appears to improve the sponginess or bubbling of the lesion that appears in later years.

Limitations and complications of the treatment consist of a failure to markedly reduce the color intensity of the lesion and the possibility of scarring. Individual response to laser treatment varies. Accordingly, a one centimeter in diameter test spot is done with the laser, and this area is allowed several months to mature before it is evaluated. A significant degree of improvement without scarring is an indication to proceed with therapy. Failure to fade the color or any significant scarring is a signal that therapy with the present technical knowledge is not indicated. There is no indication that there are any undesirable or unusual side effects caused by the use of laser light treatments. It should be noted however, that lasers have only been used in medicine for approximately 15 years, and no statistics are available for extremely long-term effects.

Heart Association Plans Nurse Conferences in Eight Georgia Cities

Between Sept. 18 and Oct. 30, 1980, the Georgia Affiliate of the American Heart Association is sponsoring eight one-day courses designed to teach nurses more about the care of patients with heart disease. The conferences will be held in Columbus, Macon, Athens, Atlanta, Valdosta, Augusta, Albany, and Savannah. MAG members who will speak at these seminars include: **C. Daniel Cabaniss, M.D.,** Columbus; **Michael Bailey,** M.D., Macon; **Dan H. Magill, III, M.D.,** Athens; **James S. Miller, M.D.,** Athens; **Joe C. Stubbs, M.D.,** Valdosta; **Paul E. Cundey, Jr., M.D.,** Augusta; and **F. Dempsey Guillebeau, M.D.,** Albany.

For more information, contact the Heart Association office in the cities where the conference will be held or the Georgia Affiliate of the Heart Association at 2581 Piedmont Rd., NE, Atlanta, GA 30324. Phone: (404) 261-2260.

IRA, Keogh– enjoy today while you plan for tomorrow.

Fulton Federal's IRA is designed for you if you are self-employed or employed but not presently covered by a qualified retirement plan.

With IRA (Individual Retirement Account), you can plan for tomorrow by contributing as much as 15% of your compensation (or earned income if you are self-employed) not to surpass $1500 in any one year. IRA allows your savings plus interest to be compounded and tax deferred until retirement or age 59-1/2. Consequently, when you do begin withdrawing money, you will probably be in a lower tax bracket, thus your taxes will be less.

Keogh is designed for you if you are self-employed. With the Keogh retirement plan, your savings plus interest is also compounded and tax sheltered until time of withdrawal. You may deposit 15% of your earned income, not to exceed $7500 in one year.

For more information, call Fulton Federal's Retirement Plan Counselors at 586-7031. IRA and Keogh, two ways to plan for tomorrow.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta • P.O. Box 1077 • Atlanta, Georgia 30370

JOURNAL
of the medical association of
georgia

Therapy of Hypertension: 1980

W. DALLAS HALL, M.D., *Atlanta**

Introduction

The Hypertension Detection and Follow-up Program (HDFP) was a study of 10,940 biracial hypertensive men and women between the ages of 30-69 years residing in 14 communities throughout the United States. Key results, ascertained between 1973-1979 and reported in December 1979, indicate that the systematic and effective management of patients with confirmed diastolic blood pressure (DBP) between 90 and 104 mm Hg is associated with a decrease in 5-year mortality from 7.4 to 5.9%, a 20% reduction when compared with patients treated less systematically.[1] Furthermore, systematic treatment was associated with a reduction in mortality in blacks as much or more than whites, and in persons 60-69 years of age as much or more than those 30-59 years of age.[2] The HDFP did not compare placebo with drug therapy for mild hypertension, but several such clinical trials are ongoing with preliminary reports.[3]

Who To Treat

The current practice is to institute drug therapy in most patients that have persistent supine or sitting DBP elevations above 90 mm Hg. For patients with initial casual DBP levels between 90 and 110 or 115 mm Hg, it is generally advisable to confirm the level of DBP with at least one and usually two repeat visits prior to beginning drug therapy. This is because 20-50% of patients with mild elevations in DBP may not demonstrate persistent elevations when BP is measured on three or more separate occasions. These patients are often referred to as "labile" hypertensives. There is no accepted standard management for labile hypertension, although risk factor counseling, weight reduction, restriction of dietary sodium intake to 1600 mg† or less, and other nonpharmacologic methods are often employed.

The validity of the blood pressure measurement must be taken into account before accepting these guidelines and appropriating patients to antihypertensive drug therapy. For example, when a standard adult blood pressure cuff is used in overweight individuals with a mid-arm circumference larger than 35-37 cm, it is probably wrong to make any firm conclusion about the actual level of blood pressure. Adult "obese cuffs" with a bladder width of 15 cm or more are now available from several manufacturers and should become standard equipment in all areas where blood pressures are taken routinely. "Thigh" cuffs are useful in certain circumstances, but are not an adequate substitute for the adult obese cuff. Even when the correct cuff is employed in patients with upper arm circumferences between 37 and 50 cm, significant discrepancies may still exist (especially in the diastolic blood pressure) between the indirectly measured cuff pressures and the directly measured intraarterial pressures.

By 1985, data should be available to help answer other questions about whether or not to initiate antihypertensive therapy for special groups of patients such as those who are above the age of 69, and those who have either isolated or disproportionate systolic hypertension. Clinical judgment and available guidelines will have to suffice for now.[4-6]

* Dr. Hall is Director, Division of Hypertension, Emory University School of Medicine and Medical Service of Grady Memorial Hospital; and Chairman, High Blood Pressure Committee, Georgia Affiliate of American Heart Association. Address reprint requests to him at Emory Univ. Sch. of Med., Thomas Glenn Memorial Bldg., Dept. of Medicine, 69 Butler St., SE, Atlanta, GA 30303.

† A 1600 mg sodium (Na) diet is approximately the same as a 4.1 gram salt (NaCl) or 70 mEq sodium (Na) diet. It represents a 50-66% decrease in the usual American salt intake.

Diuretic Therapy

Current recommendations in the United States suggest that diuretics should be the first step in the drug therapy of patients with persistent hypertension. Generally a thiazide or thiazide-like diuretic is selected over furosemide (Lasix) because of the somewhat better blood pressure lowering effect of thiazides. Since certain patients are particularly responsive to diuretic therapy, it is best to begin with the lowest dose, increasing it as necessary. Two weeks or more are necessary before the full blood pressure lowering effect of a given dose of diuretic is manifest. The initial use of prophylactic oral potassium therapy or potassium-sparing diuretics is no longer recommended except for certain patients with edema states, and those receiving digitalis preparations.[7] It would seem desirable to avoid any degree of diuretic-induced potassium loss. However, the clinical risk of life-threatening hyperkalemia associated with potassium supplements and potassium-sparing diuretics may exceed the clinical risk of severe hypokalemia (< 3.0 mEq/L) due to thiazide diuretics.[8]

There are no objective data to support the notion that one thiazide or thiazide-like diuretic has antipressor effects that are superior to another. Occasionally, however, patients maintain blood pressure control with one brand and not with another. Accordingly, it may be worth a brief trial of alternating between the thiazide and thiazide-like compounds before declaring that a patient is inadequately responsive to diuretics and in need of a second class of antihypertensive drugs.

Some groups suggest that the current use of diuretics as first line therapy for hypertension may be incorrect. They point out that further volume reduction seems illogical since patients with untreated essential hypertension often have a lower than normal plasma volume. They further argue that side effects associated with diuretic therapy may exceed those observed with other drugs such as beta-blockers; and that various studies have failed to demonstrate a statistically significant reduction in morbidity and mortality from coronary heart disease when blood pressure was reduced by treatment programs in which diuretic therapy was central. The small but significant rise in serum lipids associated with diuretic therapy has been of more concern to some than others.[9]

Certainly there are some settings where diuretics might not be the appropriate initial antihypertensive therapy. These would include patients with one or more of the following circumstances:

1. Poorly controlled gout
2. Poorly controlled diabetes
3. Hypercalcemia
4. Receiving lithium therapy
5. Serum creatinine above 3-4 mg/dL
6. Marked baseline orthostatic hypotension
7. Hypertensive disorders of pregnancy
8. Baseline serum potassium below 3.0 mEq/L
9. Unexplained sinus tachycardia
10. Photosensitivity, such as solar urticaria
11. Untreated preoperative hypertension
12. Patients who just don't want to take diuretics because of one or another past experience

Sympatholytic Agents

Methyldopa (Aldomet) may be initiated in a dose of 250 mg b.i.d. and increased up to a total daily dose of 2000 mg. Dosage schedules of t.i.d. and q.i.d. are now known to be no longer necessary in most patients. Common side effects of methyldopa include lethargy and sleepiness. Erectile dysfunction may occur in males who respond to lowering the dose or substituting another antihypertensive drug. When methyldopa is added to diuretic therapy, orthostatic hypotension may be prominent. Methyldopa hepatitis (Hb_sAg negative) often announces itself as an unexplained fever during the first month of therapy. Hemolytic anemia due to methyldopa is rare, although 10% or more of patients may have a positive Coombs test. The positive Coombs test occurs most frequently in whites on higher doses of methyldopa for 6 months or more. It may delay appropriate cross matching for several hours should the patient require transfusion for an unrelated acute bleeding episode.

Clonidine (Catapres) may be initiated in a dose of 0.1 mg b.i.d. and increased to a total daily dose of 2.4 mg or more. Dosage schedules less frequent than b.i.d. are inappropriate because certain patients may exhibit an exacerbation of blood pressure within 18-36 hours if the drug is abruptly discontinued. Other side effects include lethargy, sleepiness, and dry mouth.

Reserpine may be initiated in a dose of 0.25 mg daily, or lower amounts when it is being given in combination with a diuretic and hydralazine. If the total daily dose of reserpine is kept below 0.5 mg, the incidence of depression appears to be markedly reduced relative to that noted in older reports of patients receiving higher doses. Reserpine should probably not be used in patients with a past history of severe depression, Parkinson's disease, peptic ulcer disease, concomitant levodopa therapy, or in women with multiple risk factors for breast cancer.

Prazosin (Minipress) may be initiated in a dose of 1 mg. In outpatients, this initial dose is often given at bedtime in case the patient exhibits the "first dose effect" of orthostatic hypotension with or without syncope. In hospitalized patients, it is often wise to

observe the supine and standing blood pressure response to the first 1 mg dose of prazosin prior to writing orders for subsequent doses. The initial dose of 1 mg may gradually be increased up to a maximum daily dose of 15-20 mg. Prazosin was originally introduced as a direct vasodilator, although subsequent work has established that it has significant alpha-blocking activity.[10]

Guanethidine (Ismelin) is generally reserved for the patient whose hypertension is resistant to multiple other therapeutic efforts. It is given on a once daily schedule, beginning with 10 mg and increasing the dose once weekly (such as 10 mg, then 20 mg, then 37.5 mg, then 50 mg, then 67.5 mg, then 75 mg daily, etc.) until orthostatic hypotension and bradycardia develop as a manifestation of the drug effect. Diarrhea and impotence (especially ejaculatory incompetence) are additional common side effects.

Beta-Blockers

Propranolol (Inderal) may be initiated in a dose of 20 or 40 mg b.i.d. A total daily dose of 160 mg (80 mg b.i.d.) is usually adequate for a maximum effect on blood pressure, although higher doses (320 to 960 mg daily) may have an additional antihypertensive effect on certain high-renin or low-renin patients.[11] Propranolol is said to be a nonselective beta-blocker because it blocks both B_1 (cardiac) and B_2 (lungs, blood vessels, and others) receptors. It should not be used in patients with asthma or other bronchospastic disorders, in patients with current evidence of congestive heart failure, or in those receiving insulin. Serious adverse cardiovascular reactions can include bradycardia with shock, pulmonary edema, and high-grade atrioventricular block. These tend to occur most often in association with the use of relatively low doses (less than 100 mg daily) of propranolol in patients above 50 years of age.[12]

Metoprolol (Lopressor) may be initiated in a dose of 50 mg p.o. b.i.d.[13] The conversion scale of 50 mg of metoprolol equals 40 mg of propranolol is often used, although the exact equivalent dosage may vary considerably according to both the indication and the patient.[14] Metoprolol is said to be a cardioselective beta-blocker in that it predominantly blocks B_1 (cardiac) receptors with less effect on B_2 receptors (lung, blood vessels, and others), at least when total daily doses of 200 mg or less are employed. In relatively low doses, metoprolol has less of a tendency than propranolol to precipitate bronchospasm. Whenever possible, however, always avoid the use of beta-blockers in patients with or predisposed to bronchospasm.

Nadolol (Corgard) may be initiated in a dose of 40 mg q.d.[15] The pharmacologic effects last for at least 24 hours such that once-daily doses are recommended. The total daily dose appears to be similar to that recommended for propranolol, and no appreciable differences in their clinical effects or side effects have been well documented at this time. Nadolol, like propranolol, is a non-selective beta-blocker.

Vasodilators

Hydralazine (Apresoline) is a direct vasodilator, generally used as a Step 3 drug when blood pressure is inadequately controlled with the combination of diuretic and either sympatholytic or beta-blocker agents. Hydralazine is particularly useful when added to the combination of thiazide and reserpine, or to the combination of thiazide and beta-blocker.[16] Initial doses of 25 mg b.i.d. may be increased to total daily doses of 200-300 mg. Dosage schedules of t.i.d. and q.i.d. no longer appear necessary. Side effects of hydralazine are diminished but not necessarily abolished by concomitant beta-blocker therapy. They may include tachycardia, headaches, and precipitation or worsening of angina in patients with underlying coronary artery disease. Hydralazine-induced systemic lupus erythematosus occurs most frequently in white patients and in slow acetylators of hydralazine who have been treated with high total daily doses for relatively long periods of time.

"Occasionally, patients maintain blood pressure control with one brand of diuretic and not with another."

Minoxidil (Loniten) is potent. It is a direct vasodilator, generally reserved for patients who have demonstrated resistance to multiple other therapeutic efforts. Therapy may be initiated in a dose of 5 mg q.d., increasing to a total daily dose of 40 mg as necessary. Therapy is typically associated with reflex tachycardia and considerable fluid retention, such that beta-blockers and loop diuretics are concomitantly required. The majority of patients develop a generalized growth of all body hair, evident within 3-6 weeks and cosmetically disturbing within 3-6 months. Pericardial effusion is a feared complication that occurs in about 3% of the patients. Unexplained but sometimes impressive, new T-wave changes are not infrequent when routine electrocardiograms are monitored at 3-month intervals following initiation of minoxidil therapy.

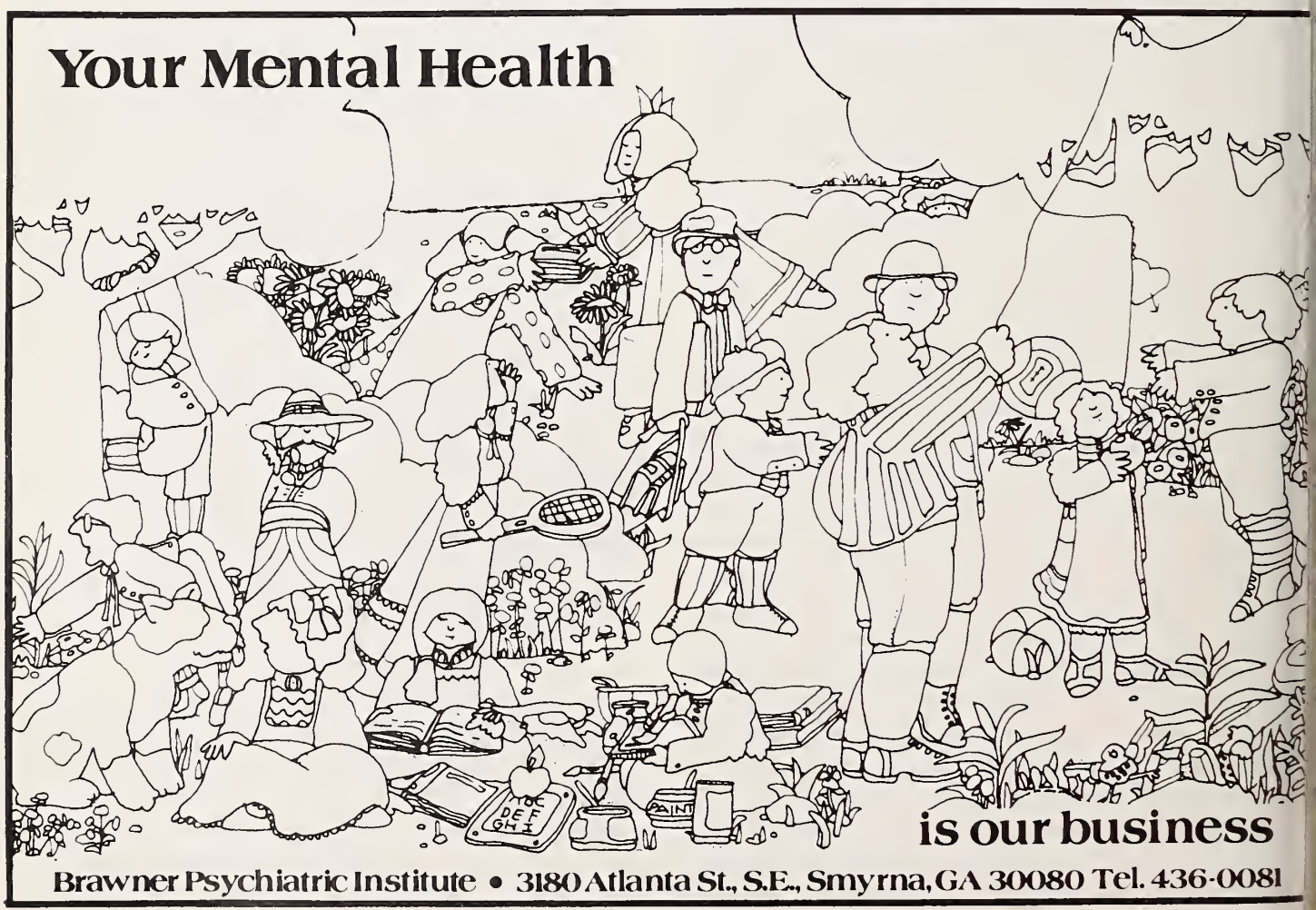
Converting Enzyme Inhibitor

Considerable interest has followed the research and development of SQ 14,225 (Captopril), an oral inhibitor of the converting enzyme (CE or Kininase II) that converts angiotensin I to its pressor form, angiotensin II. Much of the interest stems from trying to uncover the role of the renin-angiotensin system in hypertension and other clinical disorders

including congestive heart failure, scleroderma, and others. The effects of Captopril, however, are now known to be associated with more than just the reduction in angiotensin II levels. Side effects thus far noted include fever, rash, angioneurotic edema, diminished taste, and proteinuria. Continued clinical trials will help define the indications, efficacy, and safety of Captopril relative to currently available antihypertensive drugs.

References

1. Hypertension Detection and Follow-up Program Cooperative Group. Five-year findings of the Hypertension Detection and Follow-up Program. I. Reduction in mortality of persons with high blood pressure, including mild hypertension. JAMA 1979; 242:2562-2571.
2. Hypertension Detection and Follow-up Program Cooperative Group. Five-year findings of the Hypertension Detection and Follow-up Program. II. Mortality by race, sex and age. JAMA 1979; 242:2572-2577.
3. Gross F, Strasser T. Mild Hypertension. Natural History and Management. Chicago: Pitman Medical Publishing Co, 1979.
4. Dyer AR, Stamler J, Shekelle RB, et al. Hypertension in the elderly. Med Cl North Am 1977; 61:513-529.
5. Amery A, Berthaux P, Birkenhäger W, et al. Antihypertensive therapy in patients above age 60 years (Fourth Interim Report of the European Working Party on High Blood Pressure in the Elderly: EWPHE). Clin Sci Mol Med 1978; 55:263s-270s.
6. Wollam GL, Hall WD. Systolic Hypertension, in, Hurst JW (ed): Update IV: The Heart. New York: McGraw-Hill Book Company, 1980 (in press).
7. Kassirer JP, Harrington JT. Diuretics and potassium metabolism: A reassessment of the need, effectiveness, and safety of potassium therapy. Kidney Int 1977; 11:505-515.
8. Lawson DH. Adverse reactions to potassium chloride. Quart J Med 1974; 43:433-440.
9. Ames RP, Hill P. Elevation of serum lipid levels during diuretic therapy of hypertension. Am J Med 1976; 61:748-757.
10. Graham RM, Pettinger WA. Prazosin. N Engl J Med 1979; 300:232-236.
11. Hollifield JW, Sherman K, Zwagg RV, et al. Proposed mechanisms of propranolol's antihypertensive effect in essential hypertension. N Engl J Med 1976; 295:68-73.
12. Greenblatt DJ, Koch-Weser J. Adverse reactions to propranolol in hospitalized medical patients: A report from the Boston Collaborative Drug Surveillance Program. Am Heart J 1973; 86:478-484.
13. Koch-Weser J. Metoprolol. N Engl J Med 1979; 301:698-703.
14. Bengtsson C. Comparison between metoprolol and propranolol as antihypertensive agents. A double-blind cross-over study. Acta Med Scand 1976; 199:71-74.
15. Nadolol (Corgard) — A new beta-blocker. Med Lett Drug Therap 1980; 22(8):33-36.
16. Zacest R, Gilmore E, Koch-Weser J. Treatment of essential hypertension with combined vasodilation and beta-adrenergic blockage. N Engl J Med 1972; 286:617-622.



Poverty is an important risk factor associated with heat wave mortality. Data from three states are presented.

Heat Wave Related Mortality — United States

Center for Disease Control, *Atlanta**

BEGINNING the last week of June, 1980, in Texas and continuing through the first three weeks of July in 20 other, mainly southern, states a severe heat wave combined with drought-like conditions began to cause widespread discomfort, heat-related illness, and death. Hundreds of heat-related deaths were brought to public attention. Following requests for information and assistance by several states, the Center for Disease Control (CDC) sent a team of epidemiologists to Dallas, Texas, Little Rock, Arkansas, and St. Louis, Missouri, to work with state and local health officials in designing epidemiologic studies on the health impact of this heat wave. Preliminary results are reported below, and more definitive studies are being planned.

St. Louis, Missouri

During the 28-day period from June 21 through July 18, there were 18 days in St. Louis in which the official maximum temperature was 95°F or higher. Between July 7 and July 18, the maximum temperature was 95°F or higher every day. On 7 of these days the maximum was 100°F or higher, including 3 days of record-high temperatures.

The city of St. Louis requires that a preliminary death certificate be filed before a burial permit is issued. Therefore, death records already on file offered an accurate estimate of recent deaths. For deaths occurring in St. Louis, all available death certificates were reviewed for the 4-week period June 21 through July 18, 1980, and for that same period in 1979. In 1980, 886 deaths occurred in this period; in 1979, there were 230 fewer deaths. In 1980, 63.6% of the deaths where age was recorded occurred in people age 65 or older, while in 1979, 61.0% occurred in this age group.

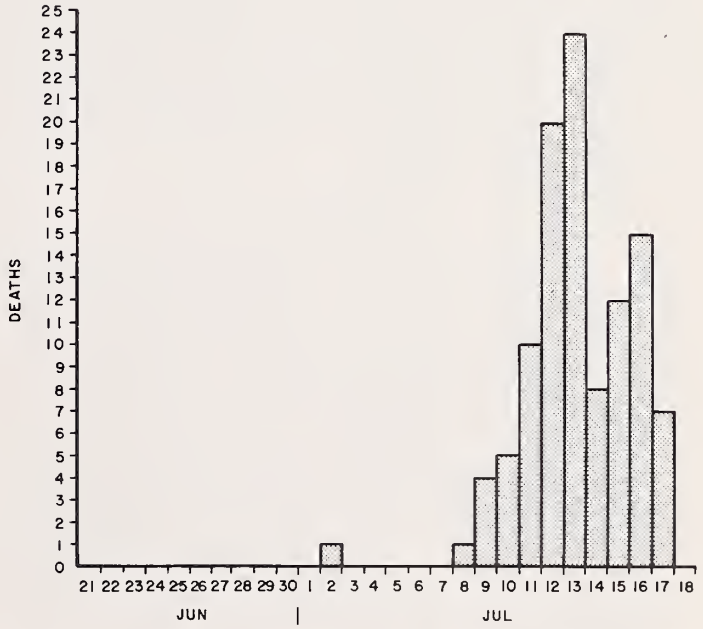


Figure 1 — Deaths from heatstroke, St. Louis, Missouri, June 21-July 18, 1980. (Source: Medical Examiner's Office, St. Louis)

Between July 2 and July 18, 1980, the Medical Examiner's Office reported 108 deaths from heatstroke in St. Louis (Figure 1). A total of 24 heatstroke deaths occurred on July 13 alone. There were three circumstances in which heatstroke was diagnosed as the cause of death: (1) when antemortem clinical signs were present (hyperpyrexia, severe central nervous system disturbances, and anhidrosis); (2) when an internal body temperature of ≥106°F was recorded in the first 24 hours after death; or (3) in persons who had not been observed before death, when close evaluation by the Medical

* Reprinted from the CDC's *Morbidity and Mortality Weekly Report*, 1980; 29(30):357-359.

Examiner's Office indicated that there was evidence of heatstroke even if the initial body temperature was below 106°F. Seventy (66.0%) of the heatstroke deaths occurred in people age 65 or older. The age range for heatstroke deaths was 32 to 93 years. The heatstroke deaths were distributed mostly in inner-city and poverty areas.

Dallas, Texas

As of July 17, Dallas had recorded 16 heatstroke deaths out of 60 potentially heat-related deaths reported to the Dallas County Medical Examiner's Office. A strict definition of heatstroke (postmortem rectal temperature ≥107°F plus antemortem clinical signs of heatstroke) limited to 16 the deaths attributed to heatstroke. The 44 that did not meet this definition were attributed to other causes, and no heat relationship was recorded on the death certificate. A map pinpointing the location of the 44 potentially heat-related deaths and the 16 heatstroke deaths showed few in affluent, suburban, or young singles areas of Dallas County. Death certificate review for 1980 indicated that, at this time, too few of these vital records have been received in Dallas County to allow analysis.

Arkansas

All available death certificates listing heatstroke as a cause of death or heat as a contributing factor were reviewed for the period of the heat wave, though it was clear that many deaths officially notified to the public had not yet been confirmed by receipt of the death certificate. Nevertheless, heatstroke deaths were recorded from all areas of this predominately rural state. A study was conducted of the date of receipt of death certificates in the state Vital Records Office in Little Rock for June and July 1979 deaths. It showed that 98% of the death certificates had been received within 3 months.

Reported by H Bruce, MD, G Gantner, MD, J Williams, MBA, RD Wochner, MD, St. Louis City Div of Health; HD Donnell Jr, MD, State Epidemiologist, Missouri State Dept of Social Services; CS Petty, MD, WJ Lene, Institute for Forensic Sciences, Dallas County, Texas; JR Williams MD, EL Berry, MD, Dallas Health Dept; CR Webb Jr, MD, State Epidemiologist, Texas State Dept of Health; JP Lofgren, MD, State Epidemiologist, R Young, MD, S Fitzhugh, MD, Arkansas State Dept of Health; Bur of Epidemiology, CDC.

Editorial Note

Because there is no agreed-upon definition of heatstroke or of the other illnesses that make up most heat-related mortality, a retrospective assessment of all death certificates within the affected areas will be needed to determine the impact of this heat wave. At this time, since there are unavoidable delays in reviewing death certificates in most jurisdictions, CDC has no estimate of heat-related mortality.

The preliminary data reported above concur with published analyses of previous heat wave mortality in the United States in implicating poverty as an important risk factor.[1] In possible contrast to the reports of large numbers of deaths in elderly people and urban residents in previous heat waves, the St. Louis data suggest that the additional deaths this year as compared to 1979 were not confined to the over-65 age group. The definitive results from Arkansas are expected to be useful in estimating the potentially considerable numbers of rural residents experiencing heat-related mortality.

Reference

1. Henschel A, Burton LL, Margolies L, Smith JE. An analysis of the heat deaths in St. Louis during July 1966. Am J Public Health 1969; 59:2232-42.

Health and Safety Tip

From the American Medical Association

535 North Dearborn Street/Chicago, Illinois 60610

Air Travelers Face Jet Lag Fatigue

Jet Lag Is Hazard

The most obvious contributor to stress in the modern world travel style is "jet lag fatigue."

An air traveler who departs from New York for Italy at 5:30 p.m. crosses seven time zones during a seven-hour flight, and arrives in Rome at 7:30 a.m. Rome time. But it is 12:30 a.m. in New York, the middle of the night for the traveler.

There is great variability in the effects of time zone changes and in one's speed of adjustment, the American Medical Association points out. The young adjust easily; older individuals more slowly.

Tourists planning months in advance for an overseas vacation should take conditioning exercises; a two to three-week program of walking up to three miles a day. Avoid the Bon Voyage party, unless it is given two or three days prior to departure.

In flight, remember that two drinks at cruising altitude are the equivalent of three or four on the ground. Eat moderately and drink sparingly. Get up and walk about the plane frequently.



The single most important requirement on arrival at the overseas destination is sleep and rest. A flight to Europe should be followed by a good night's sleep before sightseeing or business.

A simple formula often is used by tour groups. It calls for rest stops of a day after crossing four to six time zones, and two days after seven to ten zones. As crossings approach a complete reversal of the day-night cycle, three days of rest are welcomed by any traveler, particularly if in late middle age or afflicted with insomnia.

North-south flights cross no time zones, or only one, and should result in only normal fatigue.

A pretravel health review with your physician may help forestall health emergencies while on tour. There are some individuals who should not board long jet flights. These include women beyond the eighth month of pregnancy, infants less than two weeks old, individuals with contagious disease, those with large unsupported hernias, psychotics, acute respiratory infection patients (severe colds or flu), those with certain heart problems (ask your doctor), and poorly stabilized convalescent postoperative or handicapped people.

Jet lag fatigue may be held to a minimum by proper planning and proper rest on arrival.

August, 1980
Frank Chappell
Science News Editor
AMA


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action **Triavil**®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

Copyright © 1980 by Merck & Co., Inc

by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

Early and aggressive surgery remains the treatment of choice, yet the prognosis remains poor.

quamous Cell Carcinoma of ne Thyroid Gland

FREY R. LEE, M.D., M. DARIUS VOHMAN, M.D., and LLIAM J. PENDERGRAST, M.D., F.A.C.S., Atlanta*

Introduction

ARCINOMA of the thyroid gland is uncommon, occurring at a maximum annual rate of 4 cases 100,000 population. The majority of these ors are papillary, follicular, or mixed papillary icular. Squamous cell carcinoma of the thyroid is extremely rare and comprises 1.1% of all can- of the thyroid gland.[1] Numerous theories of the gin of squamous cells in the thyroid gland have n proposed, including ultimobranchial body rem- ts, thyroglossal duct structures, and squamous aplasia. Metastatic involvement of the thyroid d exists, and a thorough search for primary ors is mandatory. Primary squamous cell carci- nas of the thyroid are usually far advanced at the e of discovery, are universally radio-resistant, unresponsive to chemotherapy. These tumors, vever, should be treated aggressively with radical gery and postoperative radiation therapy in hope ontrolling local disease.

Case Presentation

he patient is a 60-year-old white woman who ially presented with an expanding mass in the t side of her neck. Although the mass was rapidly wing, she had no symptoms of dysphagia, rseness, or shortness of breath. She had no his- of goiter or other thyroid disorders, nor had she ived head and neck irradiation. Physical ex- nation revealed no pharyngeal lesion. There was a 4 x 4 centimeter hard mass in the upper aspect of the right lobe of the thyroid that was freely movable on degluttination. Thyroid function tests were normal. Thyroid scan showed no uptake over the entire right thyroid lobe with left lobe being normal. Chest x-ray was normal. At surgery, a large cystic mass was encountered in the right thyroid lobe obliterating normal thyroid tissue. A right thyroid lobectomy was performed, with removal of the right parathyroid glands en bloc. Frozen section was interpreted as squamous cell carcinoma with invasion of normal thyroid tissue. Left subtotal thyroidectomy and limited neck exploration completed the procedure. One prominent lymph node lying in the tracheo-esophageal groove was removed and sent for pathologic examination, but further exploration was negative for involved lymph nodes. While under anesthesia, direct laryngoscopy, pharyngoscopy, and bronchoscopy with biopsies and washings were performed. No carcinomatous lesions were seen. Postoperative gastrointestinal and urological x-ray examinations were negative for tumor. Mild postoperative hypocalcemia was controlled with calcium gluconate and calciferol. A total of 4,500 rads of Co_{60} radiation were administered through an anterior portal, followed with 2,000 rads with a Linac Linear Accelerator. The patient remains asymptomatic with no evidence of recurrent disease nine months postoperative.

Pathologic Description

The right lobe of thyroid gland was submitted for frozen section. It weighed 15 grams with an overall dimension of 5 x 3 x 3 cm. It was enlarged, irregular-

Dr. Lee is Chief Resident in General Surgery, Dr. Vohman is Chief of the rtment of Pathology, and Dr. Pendergrast is attending physician from the rtment of Surgery, Piedmont Hospital, and the Emory University Affiliated cal Services, Atlanta. Send reprint requests to Dr. Lee at the Dept. of Surgical ation, 1968 Peachtree Rd., Atlanta, GA 30309.

ly shaped, and was partially covered by small amounts of lobulated fat and strands of surrounding muscle. Sectioning revealed a prominent subcapsular nodule 1.5 cm. in diameter. This nodule was surrounded by a relatively thick white capsule. The rest of the tissue was for the most part made up of granular whitish-grey soft and partly friable tissue and partly by reddish-yellow thyroid parenchyma. Frozen section of this specimen was reported as keratinizing squamous cell carcinoma.

The second specimen was a portion of left lobe of the thyroid gland and measured 3 cm. in largest diameter. It was grossly covered by intact capsule and made up of yellowish-tan soft tissue. The third and fourth portions of the specimen were biopsies of pyriform sinus and pharyngeal wall, respectively. The left lobe of thyroid and pharyngeal and pyriform sinus were histologically negative for malignancy. The right lobe of thyroid gland revealed for the most part keratinizing squamous cell carcinoma with extension into the capsule and attached contiguous fibrofatty and muscular tissue (Figure 1). The pattern was typical of a squamous cell carcinoma, with branching strands and columns of large cells with eosinophilic cytoplasm, vesicular nuclei, and prominent nucleoli. There were irregular areas of central keratinization and cavitation. The nodule with thick capsule grossly described represented a follicular carcinoma made up of fairly uniform appearing cells arranged mostly in single strands and columns with occasional follicle formation (Figure 2). For the most part, the nodule was degenerated. Externally, the capsule was partially surrounded by the squamous cell carcinoma, and at no point was there evidence of histologic continuity of these two tumors. Part of the squamous cell carcinoma, however, was made up of rather anaplastic large cells which could be easily appreciated and differentiated from the smaller cells of poorly differentiated follicular carcinoma. The same type of cells were found arranged in irregular masses just outside the capsule. These cells most probably represent undifferentiated squamous cell carcinoma.

Discussion

Several theories of the histiogenesis of squamous cells present in the thyroid gland have been proposed and debated. In the fifth week of fetal life, the ultimobranchial body forms as a diverticulum of the caudal portion of the fourth branchial pouch. This epithelial body rapidly becomes incorporated into the developing thyroid gland. In lower mammals, the ultimobranchial body contributes to the fully developed gland and persists as multiple cysts and cavities lined with squamous epithelium.[2] In human studies, the ultimobranchial body is indistinguishable from the thyroid gland in embryos up to 35 mm.

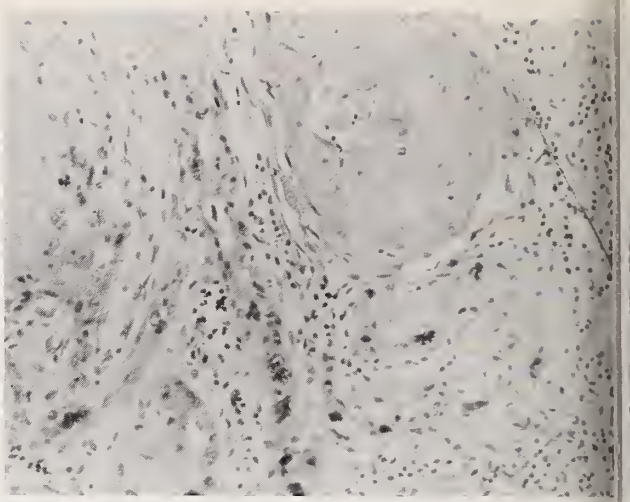


Figure 1 — Keratinizing squamous cell carcinoma with pearl fo tion, intracellular bridges, central necrosis, and surroundin flammation. Cells are large, eosinophilic, with vesicular nucle prominent nucleoli. (×300)

Goldberg and Harvey, however, report several stances of persistent squamous-lined cysts embryos in later stages of development.[3] Van D demonstrated development of cysts lined w squamous cell epithelium in rats fed a diet defici in Vitamin A, and these cysts were located centr in each thyroid lobe, corresponding to the reg occupied by the embryonic ultimobranchial bod In the adult thyroid, nests of small polygonal ba loid cells interpreted as squamous cells, are felt to remnants of the ultimobranchial body and thymu Whether these cells are stem cells involved squamous cell carcinoma of the thyroid is uns stantiated.

The median lobe of the thyroid gland devel from an epithelial thickening of the ventral p ryngeal wall. Elongation of the embryo results downward movement of the median thyroid com nent and the formation of the thyroglossal du Persistence of the distal thyroglossal duct is norm and in 50% of humans becomes the pyramidal lo of the thyroid gland. Thyroglossal duct cysts a diverticulae of the foramen cecum represent fail of obliteration of the cephalad thyroglossal d along its course of descent. Originally these thy glossal duct cysts are lined by ciliated colum epithelium, but chronic inflammation and eleva intracystic pressures cause flattening of these c with subsequent squamous transformation.[5] Pa lary carcinomas, adenocarcinomas, and squam cell carcinomas have all been described arising fr thyroglossal duct remnants.[5, 6] Histiogenesis lateral primary squamous cell carcinomas, howev cannot be ascribed to these midline squamous-lin structures.

Squamous cells have been observed in thyr glands of patients with Hashimoto's thyroidi Riedels struma, nonspecific thyroiditis, nodular g

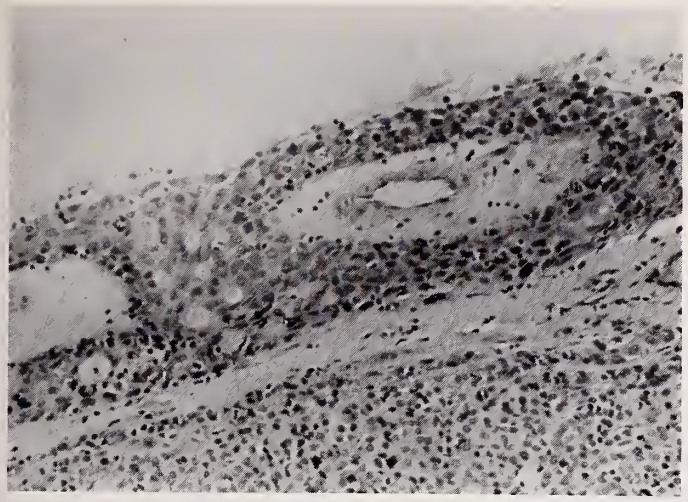


Figure 2 — Above: Well-differentiated follicular carcinoma with uniform appearing cells and occasional follicle formation. (×300) Below: Poorly-differentiated follicular carcinoma, arranged in irregular masses and columns. (×300)

ter, and thyroid abscess.[3, 7, 8, 9] It has been proposed that this squamous metaplasia occurs secondary to the chronic inflammation present in these conditions, and Dube and Joyce suggest that the chronic inflammation contributes to an immunologic or biochemical derangement that predisposes to squamous metaplasia.[7] The squamous cells in these glands are surrounded by scar tissue, lymphocytes, neoplastic cells, or are lining cysts. Klink and Menk were able to demonstrate the entire spectrum of squamous differentiation, from basal layer cells to keratinized cells with cellular bridges.[9] Histologically, this squamous epithelium is identical to normal squamous epithelium and to the metaplastic squamous epithelium found in the cervix and lung. Squamous metaplasia, found in chronic inflammatory states and pre-existing papillary thyroid carcinoma, is considered by most to be the histiogenesis of squamous cells and subsequent squamous cell carcinoma of the thyroid gland.

Transformation of pre-existing differentiated thyroid carcinoma into anaplastic and squamous cell carcinoma is well documented.[10] Nishayama presented 53 cases of anaplastic carcinoma, 42 of which were associated with pre-existing papillary, follicular, Hurthle cell, clear cell, or medullary carcinoma.[10] Due to this association and the support of other investigators, these anaplastic tumors are felt to arise from previous differentiated cancers and not as primary tumors from normal thyroid tissue.[10] Anaplastic transformation occurs in approximately 10% of follicular carcinomas and in 5% of papillary carcinomas. Late transformation to squamous cell carcinoma, however, occurs more frequently in long-standing papillary carcinomas. In a review of 70 fatal cases of papillary carcinoma, Tollefson, *et al.* found a correlation between large areas of squamous metaplasia and rapid tumor progression.[11] This anaplastic and squamous transformation universally leads to rapid tumor growth, local tissue invasion, and death.

Interestingly, the patient described in this paper had a concurrent squamous cell carcinoma and follicular carcinoma of the thyroid gland. Mixed primary malignant tumors of the thyroid gland, however, are very rare. Rube, Carrera, and Pickren[12] studied 10 cases of carcinosarcoma of the thyroid; five of these tumors were mixed fibrosarcoma and adenocarcinoma, and the remaining five were osteogenic sarcoma and adenocarcinoma. Three cases of mixed papillary and squamous cell carcinoma have been documented in the literature. In the first case, a 71-year-old Greek man presented with dyspnea and vocal cord paralysis, and he died rapidly. Diagnosis was made at autopsy.[13] The second case was in a 28-year-old printer who presented with choking and dyspnea. Although vocal cord paralysis was present, total thyroidectomy and left radical neck dissection controlled local disease, and he was reported alive and well 12 years postoperatively.[14, 15] The third case was a 51-year-old white woman who presented with a painful thyroid mass and was gaining weight. She was reported doing well 5 months after left thyroid lobectomy, isthmectomy, and left node dissection.[15] Interestingly, papillary carcinoma was found metastatic to a peritracheal lymph node. Histologically, all three tumors included areas of large irregular acini with papillary projections, lined by neoplastic columnar epithelium. In addition, there were islands of keratinizing squamous cell carcinoma, with pearl formation and central necrosis.

Secondary malignant involvement of the thyroid can occur by direct extension of primary neck tumors or by distant blood born metastases. Direct invasion of the thyroid by laryngeal, lingual tumors, and cervical node metastases is well documented. Distant metastatic involvement is much less frequent. In 20,262 patients undergoing operation on the thyroid at the Mayo Clinic, Wychulis reports 10 patients with proven blood-born metastases to the thyroid.[16] On close pathologic examination, however, microscopic metastatic foci were found in 2-24% of patients with known carcinomatosis. Willis and Mayo observed that metastases are found with greater frequency in adenomas or goiterous glands.[17, 18] Willis proposed that decreased blood flow in the adenomatous gland favors tumor implantation, and the altered iodine and oxygen content would predispose to favorable growth conditions.[18] Mortensen and Woolner, however, found no such relationship between adenomatous glands and metastasis in their study of 18 tumors metastatic to the thyroid.[19] Hypernephroma, breast, lung, gastrointestinal, and laryngeal tumors are the most common primary tumors to metastasize to the thyroid.[16] Wychulis favors an aggressive approach to thyroid glands har-

boring metastatic tumor, as surgical extirpation can afford excellent long-term results. Discovery of squamous cell carcinoma of the thyroid requires an aggressive search for occult primary tumors in the kidney, lung, pharynx, larynx, and gastrointestinal tract.

The majority of patients with primary squamous cell carcinoma are described in the fifth or sixth decade of life, and there has been no sex predilection shown.[1] In most cases, there is a history of previous goiter with rapid increase in size with associated dysphagia, dyspnea, and hoarseness. In recent reported cases, radical surgery was utilized to remove resectable tumors. Postoperative radiation was universally unsuccessful in ameliorating pain and compression symptoms and did not prolong survival. Limited experience with chemotherapy precludes evaluation at this time. Early and aggressive surgery remains the treatment of choice, but in spite of therapy, prognosis is poor.

(A more complete bibliography is available; space constraints precluded its inclusion here. Contact Dr. Jeffrey Lee at the Department of Surgical Education, Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta, GA 30309.)

References

1. Goldman RL. Primary squamous cell carcinoma of the thyroid gland: report of a case and review of the literature. Am Surg 1964; 30:247-252.
2. Van Dyke JH. The developments and activity of ultimobranchial cysts in the thyroid gland of rats on a vitamin A deficient diet. Anat Rec 1943; 82:451.
3. Goldberg HM, Harvey P. Squamous cell cysts of the thyroid with special reference to the aetiology of squamous epithelium in the human thyroid. Br J Surg 1956; 43:565-569.
4. Livolsi VA, Merino JJ. Squamous cells in the human thyroid gland. Am J Surg Path 1978; 2(2):133-140.
5. Mobini J, Krouse TB. Squamous cell carcinoma arising in a thyroglossal duct cyst. Am Surg 1974; 40:290-294.
6. Ruppman E, Georgsson G. Squamous carcinoma of the thyroglossal duct. German Med Monthly 1966; 11:442-447.
7. Dube VE, Joyce GT. Extreme squamous metaplasia in Hashimoto's thyroiditis. Cancer 1971; 27:434-437.
8. Jaffe RH. Epithelial metaplasia of the thyroid gland with special reference to the histiogenesis of squamous cell carcinoma of the thyroid gland. Arch Path 1937; 23:821-830.
9. Klinck GA, Menk KF. Squamous cells in the human thyroid. Milit Surg 1951; 109:406-409.
10. Nishiyama RH, Dunn EL, Thompson NW. Anaplastic spindle-cell and giant-cell tumors of the thyroid gland. Cancer 1972; 30:113-127.
11. Tollefson HR, Decoss JJ, Hutter RVP. Papillary carcinoma of the thyroid: a clinical and pathological study of 70 fetal cases. Cancer 1964; 17:1035-1044.
12. Rube J, Cabrera A, Pickren JW. Carcinosarcoma of thyroid gland. NY State J Med 1967; 67:716-720.
13. Ross RC. Mixed squamous cell carcinoma and papillary adenocarcinoma (adenocanthoma) of the thyroid gland. Case reports. Arch Path 1947; 44:192-197.
14. Halpert B, Thuss WG. Columnar-cell and squamous-cell carcinoma (adenocanthoma) of thyroid gland. Surgery 1950; 28:1043-1046.
15. Cocke WM, Carrera GM. Mixed squamous cell carcinoma and papillary adenocarcinoma (adenocanthoma) of the thyroid gland. Am J Surg 1964; 108:432-433.
16. Wychulis AR, Beahrs OH, Woolner LB. Metastasis of carcinoma of the thyroid gland. Ann Surg 1964; 160:169-177.
17. Mayo CW, Schlicke CP. Exogenous tumors of the thyroid gland. Am J Path 1941; 17:283-288.
18. Willis RA. Metastatic tumors in the thyroid gland. Am J Path 1931; 7:187-206.
19. Mortensen JD, Woolner LB, Bennett WA. Secondary malignant tumors of the thyroid gland. Cancer 1956; 9:306-309.

A penetrating analysis and discussion of two of the more common complications of our most serious national drug problem.

Association of Chronic Pancreatitis and Alcoholic Cirrhosis

HANS W. ADAMS, M.D., *Mississippi;* PAUL D. WEBSTER, III, M.D., *Augusta;* and DAVID L. MAINZ, M.D., *Texas**

Abstract

Autopsy records at the Medical College of Georgia were reviewed between 1960 and 1974 to identify the incidence of pancreatic disease associated with cirrhosis of the liver. Fifty-nine percent of patients with alcoholic cirrhosis had chronic pancreatitis. Calcific pancreatitis and pseudocysts were uncommon. Ascites was more common in patients with cirrhosis and pancreatitis than in those with cirrhosis alone. Chronic pancreatitis may have played a role in the increased incidence of portal vein thrombosis.

Introduction

Excessive consumption of alcohol is an increasing health problem in this country. Pathologic changes in various organs have been attributed to excessive alcohol intake. The most dramatic sequelae of chronic alcohol abuse are alcoholic hepatitis with or without cirrhosis and chronic pancreatitis. Although these diseases are known to occur frequently in alcoholic patients, it has been the general opinion that they are mutually exclusive or at least rarely occur together in the same patient. Janowitz and Bayer[1] commented that alcoholic hepatitis and pancreatitis or cirrhosis and chronic pancreatitis rarely occurred together. Postmortem studies revealed an occurrence of concomitant pancreatic and liver disease in 28%, 39%, and 46% of patients with alcoholic cirrhosis.[2, 3, 4] Several studies reported on pancreatic function in patients with alcoholic cirrhosis. They suggested that as many as 50% of cirrhotics had decreased pancreatic enzyme and bicarbonate secretion.[5, 6, 7]

This paper reports the autopsy incidence of chronic pancreatitis in patients with alcoholic cirrhosis seen at the Medical College of Georgia hospitals in a 14-year period, along with significant clinical data obtained from case records.

Materials and Methods

The hospital records of 2,165 patients who had necropsy at the Eugene Talmadge Memorial Hospital or the Veterans Administration Hospital in Augusta from 1960 to 1974 were reviewed. Records were selected if a pathologic diagnosis of hepatic cirrhosis or chronic pancreatitis was made. Forty-seven cases were excluded because of the presence of visceral cancer, usually with hepatic metastases. In such a patient, we could not be certain of the temporal or etiologic relationships between the pancreatic and liver disease. Five patients were excluded because of the presence of abscesses in the abdomen which virtually destroyed the pancreas and rendered pathologic interpretation impossible. Twenty-nine patients were excluded because of a diagnosis of acute pancreatitis. In these patients, the presence of widespread hemorrhage and necrosis obliterated

* This study is based on information obtained from the Medical Service (MRIS #'s 00828 & 5442), Veterans Administration Hospital, and the Department of Medicine, Medical College of Georgia, Augusta. Dr. Adams is Assistant Professor, Department of Medicine, Medical College of Georgia. His current address is P.O. Box 4717, Biloxi, MS, 39531; Dr. Webster is Professor and Chairman, Department of Medicine, Medical College of Georgia; Dr. Mainz is Assistant Professor, Department of Medicine, Medical College of Georgia, and Research Associate, Veterans Administration Hospital, Augusta, Georgia. Current Address: Veterans Administration Hospital, Kerrville, Texas. Address correspondence and reprint requests to Dr. Adams at his current address.

TABLE 1 — Sex Distribution

	Men	Women
Alcoholic cirrhosis	78	27
With chronic pancreatitis	55	7
Non-alcoholic cirrhosis	12	10
With chronic pancreatitis	0	0
Chronic pancreatitis without liver disease	15	6

pancreatic anatomy to such a degree that the presence of chronic pancreatitis could not be ascertained. The search yielded 172 charts suitable for the study.

Cirrhosis was diagnosed macroscopically if either macronodular, micronodular, or a combination of these forms were present. Microscopically, fibrosis and regenerative nodules were seen. Fatty changes, Mallory bodies, hepatic cell necrosis, and polymorphonuclear infiltration were frequently present.

Chronic pancreatitis was diagnosed macroscopically if the pancreas was firm, atrophic, or nodular. Microscopically, diffuse scarring, fibrosis, and dilatation of pancreatic ducts were seen. Fat necrosis as well as polymorphonuclear and lymphocyte infiltration were occasionally described.

The charts were reviewed to determine the presence, duration, and degree of alcohol abuse, pancreatitis, malabsorption, liver disease, diabetes mellitus, or gallstones. Patients were divided into those with alcoholic liver disease or non-alcoholic liver disease on the basis of history. Patients were placed in the alcoholic group if they met any of the following criteria: (a) consumed 180 grams of alcohol as whiskey, beer, or wine for at least 18 months prior to death; (b) had frequent hospitalizations due to alcoholism; or (c) were unemployed because of alcoholism. The patients were not classified as alcoholic or nonalcoholic on the basis of liver morphology; i.e., the presence of macronodular or micronodular cirrhosis.

The amount of alcohol ingested was determined from hospital records. Patients with cirrhosis and/or pancreatitis consumed at least 180 to 200 grams of alcohol per day. The duration of alcoholism in both groups averaged 15 years.

Results

There were 151 patients with a primary diagnosis of cirrhosis and 21 patients with a primary diagnosis of chronic pancreatitis. A total of 105 patients were considered to have cirrhosis on the basis of chronic alcoholism. Of these patients, 62 (59%) had pathologic changes of chronic pancreatitis. Forty-six were non-alcoholic, and none of these patients had pathologic changes of chronic pancreatitis. Chronic pancreatitis was a primary diagnosis in 21 patients, and none of these had cirrhosis.

TABLE 2 — Mortality Rate

Age	Number of Patients Cirrhosis*	Cirrhosis and Chronic Pancreatitis†
30-40	2 (5%)	10 (16%)
41-50	17 (40%)	14 (23%)
51-60	14 (33%)	22 (35%)
61-70	8 (19%)	13 (21%)
71-80	2 (5%)	3 (5%)

* 43 patients with cirrhosis.
† 62 patients with cirrhosis and chronic pancreatitis.

Table 1 shows the sex distribution of all patients. The ratio of men to women with alcoholic disease was 3:1. The ratio in non-alcoholic patients was equal. A total of 71% of the men and 26% of the women with alcoholic liver disease had associated chronic pancreatitis.

Table 2 shows mortality according to age of patients with cirrhosis and those with cirrhosis and chronic pancreatitis. The mortality rates appeared similar to those in patients with cirrhosis alone.

Table 3 tabulates the primary diagnoses used in this study with clinical diagnoses determined from historical data. Diabetes mellitus was unusual and occurred at approximately the same frequency in patients with alcoholic cirrhosis as those with alcoholic cirrhosis plus chronic pancreatitis. A history of acute pancreatitis was obtained in 11% of patients with alcoholic cirrhosis and chronic pancreatitis and in 19% of patients with chronic pancreatitis alone. Patients with only alcoholic cirrhosis did not have a prior clinical history of acute pancreatitis. Cirrhosis was diagnosed antemortem in the clinical records of only 28% of patients with alcoholic cirrhosis and in only 11% of patients with cirrhosis plus pancreatitis. A history of pancreatic disease was noted infrequently in all groups of patients.

Table 4 shows the incidence of gallstones in these patients. The incidence increased in patients with alcoholic cirrhosis compared to those with nonalcoholic cirrhosis. Patients with cirrhosis and those with cirrhosis plus chronic pancreatitis had a similar incidence of gallstones. Thus, one could not invoke gallstones as an etiologic factor in chronic pancreatitis.

Values for serum albumin, bilirubin, and alkaline phosphatase were similar and did not help distinguish between the groups of patients. An analysis of pancreatic weights revealed the following: cirrhosis only 80.8 ± 16 grams, cirrhosis plus chronic pancreatitis 62.9 ± 26 grams, and chronic pancreatitis only, 71.7 ± 25 grams. These differences in pan-

TABLE 3 — Clinical Diagnosis

Necropsy Diagnosis	Diabetes Mellitus	Acute Pancreatitis	Cirrhosis
Alcoholic cirrhosis*	3 (7%)	0	12 (28%)
Alcoholic cirrhosis with pancreatitis†	5 (8%)	7 (11%)	7 (11%)
Non-alcoholic cirrhosis‡	0	0	0
Chronic pancreatitis§	3 (14%)	4 (19%)	0

* 43 patients with alcoholic cirrhosis.
† 62 patients with alcoholic cirrhosis and pancreatitis.
‡ 46 patients with non-alcoholic cirrhosis.
§ 21 patients with chronic pancreatitis.

TABLE 4 — Incidence of Gallstones

Alcoholic cirrhosis	18%
Cirrhosis with chronic pancreatitis	17%
Cirrhosis without chronic pancreatitis	20%
Non-alcoholic cirrhosis	10%

TABLE 5 — Complications

	Cirrhosis*	Cirrhosis & Pancreatitis†	Pancreatitis‡
Portal vein thrombosis	6 (14%)	17 (27%)	2 (5%)
Ascites	9 (21%)	32 (52%)§	1 (5%)
Gastrointestinal bleeding	17 (40%)	23 (37%)	5 (24%)
Peptic ulcer disease	6 (14%)	6 (10%)	4 (19%)
Portal systemic encephalopathy	4 (9%)	3 (5%)	—
Calcific pancreatitis	0	1 (2%)	2 (10%)
Pseudocyst	0	1 (2%)	1 (5%)

* 43 patients with cirrhosis.
† 62 patients with cirrhosis and pancreatitis.
‡ 21 patients with pancreatitis.
§ Statistically significant at $P<0.05$.

creatic weights were not statistically significant. Variations in weights of the pancreas may be explained by inadequate trimming of fat prior to its being weighed. It was of interest, however, that 50% of patients with alcoholic cirrhosis plus chronic pancreatitis had pancreatic weights of less than 50 grams. This indicated rather severe pancreatic atrophy.

Table 5 shows complications in these groups of patients. Portal vein thrombosis was found in six patients with cirrhosis; 17 patients with cirrhosis plus chronic pancreatitis; and in two patients with chronic pancreatitis alone. The incidence of portal vein thrombosis in patients with cirrhosis plus chronic pancreatitis was twice that in the other groups. Patients with cirrhosis plus chronic pancreatitis had a statistically significant greater incidence of ascites than did patients with cirrhosis alone. The incidence of gastrointestinal bleeding, peptic ulcer disease, and portal systemic encephalopathy was the same in the groups of patients with cirrhosis.

Discussion

A widely held clinical premise suggests that if alcohol damages the liver, the pancreas is likely to be spared and vice versa. It has been suggested that alcoholic cirrhosis of the liver and chronic pancreatitis are rarely seen in the same patient.[1] We decided to examine this premise for the following reasons: (a) an understanding of the metabolic effects of alcohol on the liver and the pancreas would suggest that this "clinical truism" is erroneous; (b) earlier published reports failed to show the association, because patients with a variety of pathologic types of liver disease were included; (c) earlier recognition of the association of chronic pancreatic and liver disease would facilitate management of both diseases.

Lieber[8, 9] has shown that alcohol damages the liver and causes cirrhosis in experimental animals. While the data are not as compelling regarding the effects of alcohol on the pancreas, work by Sarles and others[10, 11] clearly suggests that alcohol does damage the pancreas.

We examined the autopsy records of patients who had died with alcoholic liver disease and found that chronic pancreatitis was present in 59%. On the other hand, no patient with "non-alcoholic liver disease" had evidence of chronic pancreatitis at autopsy.

To determine the true association of liver and pancreatic disease in the alcoholic, we separated patients into alcoholic and non-alcoholic groups. In our study, patients were grouped according to history rather than morphologic types of cirrhosis. This separation was justified by the observations of Popper[12] who stated that while portal cirrhosis was the most common presentation of alcoholic liver disease, many alcoholics presented with macronodular cirrhosis.

Stinson, Baggenstoss, and Morlock[13] studied the histologic variations observed in the pancreas of 75 persons with cirrhosis of the liver. A history of excessive use of alcohol was recorded in 29 (39%) of these patients. These observers did find an increased incidence of interstitial fibrosis and pancreatic ductal dilatation in patients with cirrhosis as compared to control patients. They concluded that pancreatic disease and liver disease were frequently associated but they did not deal with the question of the role of alcohol.

Kirshbaum and Shure[3] examined 356 patients with alcoholic cirrhosis of the liver seen at the Cooke County Hospital. Pancreatic fibrosis was present in 36.2% of these cases. In many instances, the type of liver disease described would be recognized today as acute alcoholic hepatitis.

Sobel and Waye [4] reported on pancreatic changes seen in various types of cirrhosis in alcoholics. Of 55 alcoholic cirrhotic patients, they found that 45% of 55 patients with alcoholic cirrhosis also had pancreatic changes, whereas only 15% of 32 patients with non-alcoholic liver disease had pancreatic changes. They concluded that patients with alcoholic cirrhosis had a three-fold greater incidence of significant pancreatic changes than controls of non-alcoholic cirrhotic patients.

Pollack and Gerber[14] found pancreatic fat necrosis in 13 of 49 patients with Laennec's cirrhosis. Woldman *et al*[15] found that 70% of patients with fatty liver or cirrhosis had pancreatic fibrosis.

Pancreatic function has been studied in patients with alcoholic cirrhosis, but the variation in methods renders comparison of results difficult. Sun examined 20 patients with Laennec's cirrhosis and found 10 with steatorrhea. All patients had normal small bowel biopsies, small bowel x-rays, and D-xylose absorption studies. Cholecystokinin-Secretin function tests were abnormal in 15 of the 20 patients. Pancreatic hypersecretion was noted in 10 of 20 patients and decreased bicarbonate and amylase secretion in 11 of 20. Baraona[5] noted decreased pancreatic secretion in 13 of 21 patients with various morphologic types of cirrhosis. Zieve and his coworkers[16] studied 34 patients with liver disease; 29 had cirrhosis and 5 had "fatty livers." Two-thirds of these patients had ascites. Forty percent of the patients had low amylase and bicarbonate secretion; 60% had low secretion of pancreatic enzymes. Two-thirds of these patients had pancreatic secretory volumes greater than normal.

Van Goidsenhoven *et al*[17] reported 25 patients with cirrhosis; 18 had Laennec's type. The secretin test was abnormally low in 44% of the patients, and 48% had pancreatic hypersecretion. Steatorrhea was seen in 12 of 21 patients (57%). Gross and his coworkers[18] studied pancreatic function in nine patients with parenchymal liver disease and found normal or increased secretion of bicarbonate, volume, and enzymes in all patients. He found steatorrhea in six of the nine patients. Williams[19] reported 26 patients, including five with Laennec's cirrhosis, and found steatorrhea in 18 of 23 (78%). In a recent study, Moeller *et al*[20] examined pancreatic function in patients with alcoholic cirrhosis. Six patients had malabsorption, but only one of these had pancreatic insufficiency. These studies point to the increased incidence of pancreatic dysfunction in patients with alcoholic cirrhosis, but standardized tests of pancreatic function should be performed.

Gambill *et al*[21] found in a series of 56 patients with chronic pancreatitis that calcification was present in 22 (40%). In this group of patients, pancreatitis was attributed to excess alcohol consumption in 50% and to biliary tract disease and other causes in the remaining. Several authors have reported a high incidence of alcoholism in patients who developed calcifications in the pancreas.[22, 23] In our series, one of 62 patients with both alcoholic cirrhosis and chronic pancreatitis had calcification; two of 21 patients with chronic pancreatitis had calcification. The reason for this low incidence is not known. Of note, however, is the fact that our study includes a large unselected group of alcoholic cirrhotics and may reflect a truer incidence of pancreatic calcification. There would appear to have been adequate time to develop pancreatic calcification, since the duration of alcohol abuse was great, and many of the pancreases weighed only 30-40 grams.

Gambill *et al*[21] found pseudocysts in 18% of 56 patients. Edmonson *et al*[24] stated that pseudocysts occurred more frequently in patients with chronic pancreatitis and calcification. Bockus[25] reported that 25% of patients coming to surgery for chronic pancreatitis had pseudocysts. In our series, pseudocysts were seen in one patient with alcoholic cirrhosis and chronic pancreatitis and in one patient with chronic pancreatitis.

Acknowledgment

The authors wish to acknowledge the secretarial assistance of Ms. Jane Long.

References

1. Janowitz HD, Bayer M. Alcohol and pancreatitis. Ann Int Med 1971; 74:444-445.
2. Marin GA, Clark ML, Senior JR. Studies of malabsorption occurring in patients with Laennec's cirrhosis. Gastroenterology 1968; 56:727-736.
3. Kirshbaum JD, Shure N. Alcoholic cirrhosis of the liver; a clinical and pathologic study of 356 fatal cases selected from 12,267 necropsies. J Lab Clin Med 1942; 28:721-731.
4. Sobel HJ, Waye JD. Pancreatic changes in various types of cirrhosis in alcoholics. Gastroenterology 1963; 45:341-344.
5. Baraona EH, Orrego O, Fernandez E, *et al*. Absorptive function of the small intestine in liver cirrhosis. Am J Dig Dis 1972; 7:318-330.
6. Sun DEH, Albacete RA, Chen JK. Malabsorption studies in cirrhosis of the liver. Arch Int Med 1967; 119:567-572.
7. Losowsky MS, Walker BE. Liver disease and malabsorption. Gastroenterology 1969; 56:589-600.
8. Rubin E, Lieber CS. Alcohol-induced hepatic injury in non-alcoholic volunteers. N Engl J Med 1968; 278:869-876.
9. Lieber CS. Liver adaptation and injury in alcoholism. N Engl J Med 1973; 288:356-364.
10. Sarles H, Tiscornia. Ethanol and chronic calcifying pancreatitis. Med Clinics NA 1974; 58:1333-1346.
11. Webster PD. Secretory and metabolic effects of alcohol on the pancreas. Ann NY Acad Sci 1975; 252:183-186.
12. Popper H, Rubin E, Krus S, Schaffner F. Postnecrotic cirrhosis in alcoholics. Gastroenterology 1960; 39:669-686.
13. Stinson JC, Baggenstoss AH, Morlock CG. Pancreatic lesions associated with cirrhosis of the liver. Amer J Clin Path 1952; 22:117-125.
14. Pollack AD, Gerber IE. Abdominal visceral lesions associated with primary disease of the liver. Arch Path 1943; 36:608-611.

15. Woldman ED, Fishman ED, Segal AJ. Relation of fibrosis of the pancreas to fatty liver and/or cirrhosis. An analysis of one thousand consecutive autopsies. JAMA 1959; 169:1281-1283.
16. Zieve L, Mulford B. Secretion of pancreatic enzymes. III: Response of patients with cirrhosis to secretin and pancreozymin. Am J Dig Dis 1967; 12:303-309.
17. Van Goidsenhoven GE, Henke WJ, Vacca JB, Knight WA. Pancreatic function in cirrhosis of the liver. Am J Dig Dis 1963; 8:160-173.
18. Gross JB, Comfort MW, Wollaeger EE, Power MH. External pancreatic function in primary parenchymatous hepatic disease as measured by analysis of duodenal contents before and after stimulation with secretin. Gastroenterology 1950; 16:151-161.
19. Williams CN, Sidoror JJ. Steatorrhea in patients with liver disease. Can Med Assoc J 1971; 105:1143-1155.
20. Moeller DD, Dunn GD, Klotz AP. Pancreatic function in malabsorbing alcoholics. Am J Dig Dis 1974; 19:779-784.
21. Gambill EE, Baggenstoss AH, Priestley JT. Chronic relapsing pancreatitis: Fate of 56 patients first encountered 1939 to 1943 inclusive. Gastroenterology 1960; 39:404-413.
22. Howard JN. Pancreatic Calcification. In, *Surgical Disease of the Pancreas,* Vol 2. JN Howard and GL Jordan, JR (eds). Philadelphia: JB Lippencott Co, 1960, pp 203-222.
23. Sarles H, Gerolmadi-Santandrea A. Chronic pancreatitis. In, *Clinics in Gastroenterology,* Vol 1, No. 1. Philadelphia: WB Saunders, 1972, pp 178-182.
24. Edmondson HA, Bullock WK, Mehl JW. Chronic pancreatic lithiasis; a clinico-pathologic study of 62 cases of chronic pancreatitis. Am J Path 1949; 25:1227-1247.
25. Bockus HL. Chronic pancreatitis: A review of etiologic and clinical aspects. Gastro Endo Nut 1971; 25:303-322.

NUTRITION SERVICES CENTER

PHYSICIAN REFERRAL

• Computerized Nutrition Analysis
• Diet Therapy by
Clinical Nutrition Specialists
• Hospital Consults

Nutrition Services Center
Emory University School of Medicine
1712 Clifton Road
Atlanta, Georgia 30329
Telephone (404) 329-5737

THE GOVERNMENT CAN DO EVERYTHING THE UNITED WAY DOES. ONLY THEY WRAP IT UP FOR YOU IN NICE RED RIBBON.

MILES AND MILES OF IT.



One of the best things about United Way is not what it *does,* but what it *doesn't* do.

For instance, because United Way is run almost entirely by volunteers, it is able to return an amazing 89¢ of every dollar to people who need it. That means less than 11% goes for administrative costs.

So it doesn't waste your money.

And because United Way is re-created each year with a combination of old and new volunteers, it doesn't become over encumbered with huge staffs of people who might actually get in the way of progress.

So it doesn't strangle you in red tape.

All of which means that because of what United Way *doesn't* do, it can do a much better job at what it *does* do.

Helping people.

United Way

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Definitive microscopic changes were recognizable as early as 90 minutes following compromise of blood supply.

A Pilot Study of Early Ischemic Lesions in the Myocardium

MEHBOOB FATTEH, M.D., ***Augusta****

Introduction

In the past, myocardial ischemia has been studied in experimental animals using both light and electron microscopy. Histochemical studies, with configurational stains for myosins, showed alterations of myofibrils in experimental myocardial infarction in dogs within 1 to 2 hours.[1] Other investigators studied early ischemic lesions by inducing temporary and permanent occlusion of a coronary artery.[2] Some investigators described "wavy fibers" in early infarcts and interpreted them as an indicator for early ischemic lesions.[3, 4]

TP-Thiazine Red R stain for polarization microscopy has been used to study myofibrils in the endothelial cells.[5] This method was also applied to study myofibrils in the myoepithelial cells and lesions of striated muscle in autopsy material.[6, 7] However, this method had not been used to study the pathology of experimental myocardial ischemia.

In this study, early experimental myocardial ischemic lesions in the hearts of dogs were examined using polarization microscopy on specimens fixed in Carnoy fixative and stained with TP-Thiazine Red R.[8] The lesions found in these experiments were compared with similar types of lesions found in the myocardium of 19 human autopsies. In all cases, there was no evidence of myocardial ischemia on clinical examination of the patients or on gross examination of the heart.

Materials and Methods

The study was carried out on experimental dog myocardium and human autopsy myocardium. Blocks of heart from both sources were fixed in Carnoy fluid or Methacarn, (methanol-chloroform-glacial acetic acid 6:3:1) solution and embedded in paraplast by autotechnicon.[9] Sections were cut at 5u. The TP-Thiazine Red R stain was found most suitable for demonstration of myosin and related proteins under light and polarization microscopy. (The details of this method were previously described in a paper by Puchtler.[5]) This study was carried out in several stages.

Stage I

The blocks of myocardium with ischemia were obtained by inducing thromboses of the left coronary arteries of several dogs' hearts.[10, 11, 12] This was done with an electrode (Figures 1 and 2). The hearts were removed at different times after the formation of the thrombi. Selected for our study were those cases in which ischemia was induced at 15, 36, 44, and 90 minutes, and at 3, 6, and 10 hours. The duration of the ischemia refers to the time electrical current was commenced to the time the animal was killed to examine the heart. Control blocks were taken from the myocardium supplied by unthrombosed coronary arteries (Figure 3). The myocardium was fixed and stained as previously mentioned. The slides were carefully studied with light and polarization microscopy. A limited number of important baseline observations were made from this study.

Stage II

The anatomical diagnoses were examined, and 283 cases were selected for study in which the myocardium was fixed in Carnoy fixative at the time of autopsy examination. Stained with TP-Thiazine Red R, the specimens were studied under light and

* Dr. Fatteh is with the Department of Pathology at the Medical College of Georgia, Augusta, GA 30912.

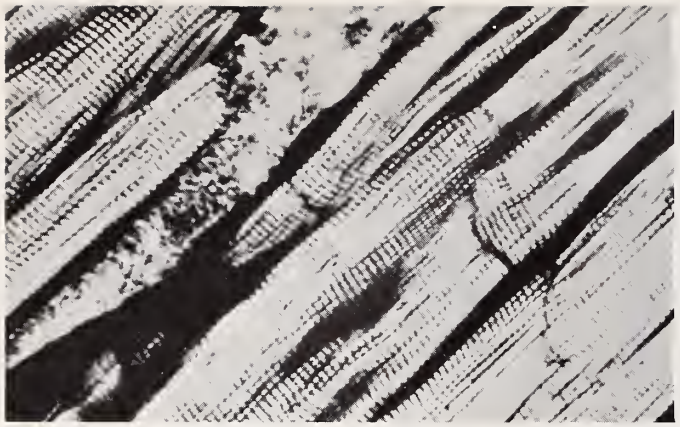


Figure 1 — Myocardium that has undergone experimentally induced ischemia. Note red clumpy appearance of the myocardial fiber. One can confuse this with fiber overlap or collection of lysed blood in or around the fiber. TP Thiazine Red R x 630. Light microscopy.

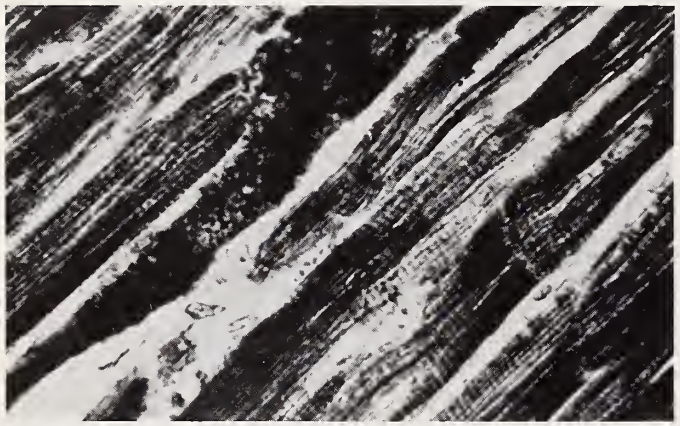


Figure 2 — Same area as in Figure 1, examined under polarization microscope. One can see distinct fiber damage shown here as loss of birefringence. Clumped myosin shows intense hyperrefringence. TP Thiazine Red R x 630.



Figure 3 — 90-minute control section of experimental dog myocardium. There is no widening of intercalated discs, nor is there clumping of myosin. TP Thiazine Red R x 400. Polarization Microscopy.

polarization microscopy. None of the patients selected had had a recent myocardial infarction. Of these, 255 cases were removed from the study either because the myocardium did not show early microscopic ischemic changes or because it showed gross and/or microscopic infarcts of more than 6 hours duration.

Stage III

The gross examination of the hearts from 19 of the 28 patients was carried out. Nine cases were not available for gross examination. The remaining 19 cases were extensively studied for early ischemic lesions. These lesions were compared with the baseline observations made on the dog hearts.

Stage IV

An attempt was made to study the patients' charts of these 19 cases to examine and correlate the enzyme levels and EKG changes. Since these patients died rapidly, terminal EKG and enzyme studies were not carried out.

Results

From the study of the dog hearts, it was noted that ischemic lesions had several patterns. Such lesions were better appreciated in longitudinally cut fibers because they had strong birefringence. The observations were as follows:

(1) The earliest lesions of 90 minutes showed up as widening of intercalated discs. The widened area had a loss of birefringence, similar to what one sees in normal intercalated discs. The I Banks were also widened. Occasional myosin clumping was also seen.

(2) The lesions older than 90 minutes had focal, irregular, nodular clumping of myosin, with adjacent areas having a loss of birefringence. The clumped myosin showed intense birefringence which made it easier to locate under low magnification. With conventional H&E stains, the same area was difficult to locate or was missed. Such changes were seen in ischemia of 2 to 3 hours duration.

(3) The next stage was that of generalized widening of intercalated discs with marked linear thickening (rather than clumping) of myosin, with increased birefringence. Such changes were seen in ischemia of 3 to 4 hours duration.

(4) Ischemic changes beyond this stage were more extensive but had irregular patterns. Some cases showed overlapping morphologic patterns. The severity of change, however, was directly proportional to the duration of the ischemia.

Summary

From this pilot study, it is reasonable to conclude that ischemic changes in the myocardium can be seen as early as 90 minutes duration. Application of this method on autopsy material showed that such lesions can be seen and located easily with the help of polarization microscopy on tissue stained with TP-Thiazine Red R.

Credits

This investigation was supported by USPHS Research Grant #HL12147 from The National Heart and Lung Institute and from Research Grant #HL3973 from the National Institutes of Health. I am thankful to Dr. A. B. Chandler and Dr. T. Pope for allowing me to use experimental material obtained for their research. I am also thankful to Dr. Puchtler for her expert advice during the entire study.

References

1. Hollingsworth AS, Teabeaut JR, Puchtler H. Applications of newer histochemical stains to myocardial infarcts. Lab Invest 1967; 16:653.

2. Sommers HB, Jennings RB. Experimental acute myocardial infarction: histologic and histochemical studies of early myocardial infarcts induced by temporary or permanent occlusion of a coronary artery. Lab Invest 1964; 13:1491-1503.

3. Bouchardy B, Manjo G. A new approach to the histologic diagnosis of early myocardial infarcts. Cardiology 1971/71; 56:327-332.

4. Bouchardy B, Manjo G. Histopathology of early myocardial infarcts. Am J Pathol 74:301-330.

5. Puchtler H, Sweat F, Terry MD, Conner HM. Investigation of staining, polarization and fluorescence microscopic properties of myoendothelial cells. J Microsc 1969; 89:95-104.

6. Waldrop, Puchtler, Carter, Valentine. Polarization and fluorescence microscopic properties of myoepithelial cells. Histochemistry 1976; 40:281-289.

7. Meloan SN, Waldrop F, Puchtler H. Polarization microscopic of early lesions of striated muscles. Lab Invest 1975; 32:431.

8. Waldrop, Puchtler, Valentine. Polarization microscopic studies of connective tissue stained with picro-sirus red F_3BA. Beitz Path Anat 1973; 150:174-187.

9. Puchtler H, Waldrop FS, Meloan SN, Terry MS, Conner HM. Methacarn (methanol-carnoy) fixation; practical and theoretical considerations. Histochemie 1970; 21:97-116.

10. Pope JT, Chandler AB, Asokan SK, Pollard D. Morphologic and angiographic study of the evolution experimental coronary thrombosis. Circulation 48 Supp 1973; 4:204.

11. Chandler AB, Pope JT. Arterial thrombosis in atherogenesis. IFMA Scientific Symp No 4 The Haugue 11/12 June 1974.

12. Chandler AB. Reversed and repair of vascular injury in thrombosis. Throm Diath Hemorrh Sup 1970; 40:273.

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



BMW

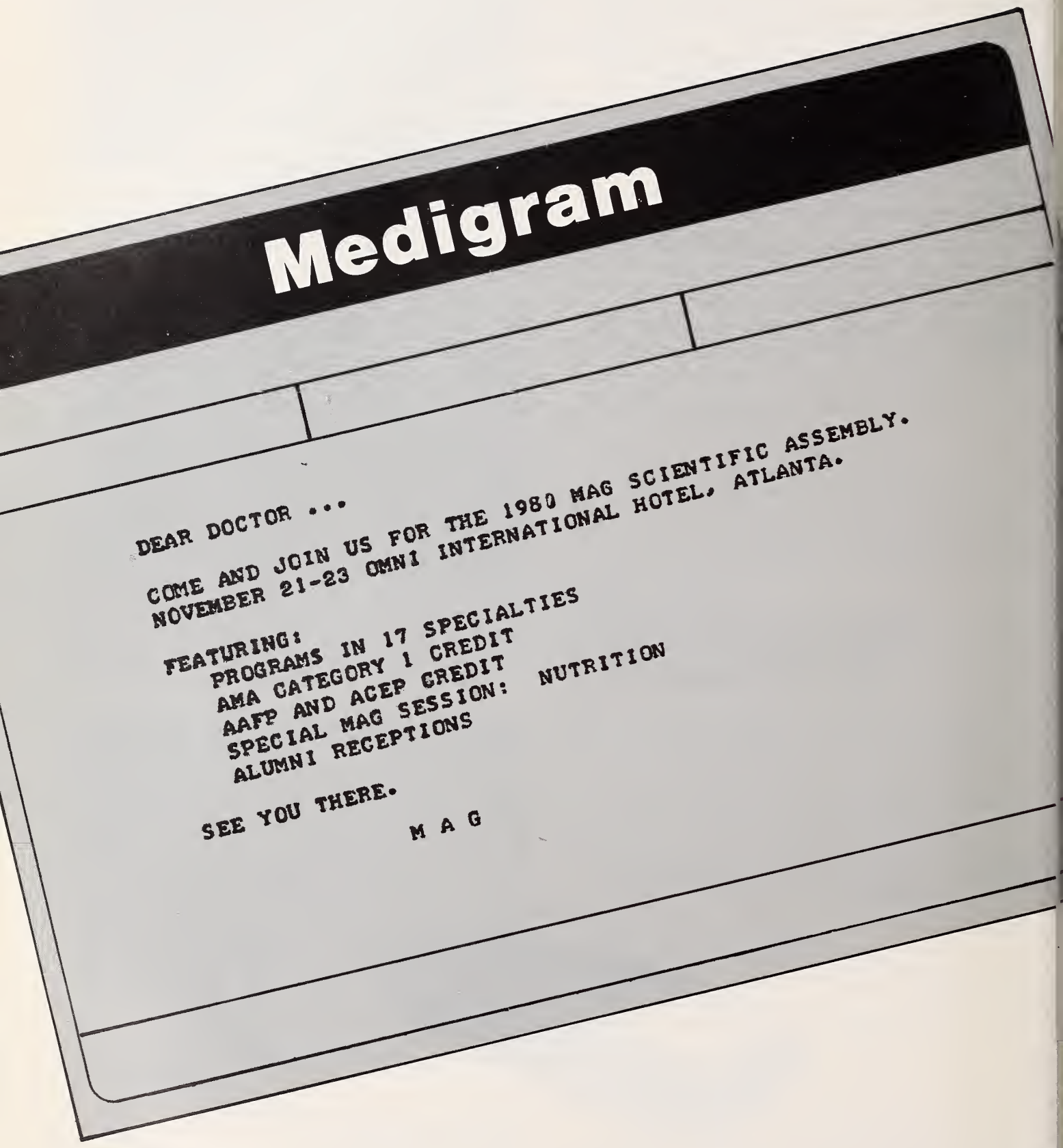
THE ULTIMATE DRIVING MACHINE.

BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730


Medigram
DEAR DOCTOR ...
COME AND JOIN US FOR THE 1980 MAG SCIENTIFIC ASSEMBLY.
NOVEMBER 21-23 OMNI INTERNATIONAL HOTEL, ATLANTA.
FEATURING:
PROGRAMS IN 17 SPECIALTIES
AMA CATEGORY 1 CREDIT
AAFP AND ACEP CREDIT
SPECIAL MAG SESSION: NUTRITION
ALUMNI RECEPTIONS
SEE YOU THERE.
M A G

A newly encountered clinical complication is described.

Delayed Diazepam Withdrawal Syndrome: A Case of Auditory and Visual Hallucinations and Seizures

DEEN BANDHU CHANDORA, M.D., *Augusta**

Introduction

DIAZEPAM WAS introduced for clinical use in 1963, and since then many articles have appeared about its addictive and withdrawal effects.[1-4] In an extensive review of literature, Maletzky and Klotter[2] did not find conclusive studies to show the addictive properties of diazepam even after 2 years of therapeutic use, but they reported withdrawal symptoms such as agitation, anxiety, and insomnia from their own study. Hallucinations as withdrawal symptoms were reported in 1976 when diazepam was abruptly withdrawn.[3] Later on it was realized that the duration of its use rather than the dosage is more important in causing dependence and precipitating withdrawal symptoms.[5] The present case report is meant to draw attention to another little known facet of this problem, namely, delayed onset of diazepam withdrawal syndrome.

Case Report

A 63-year-old, white, married male was admitted to the hospital for nervousness, fitful sleep, depression, indigestion, and generalized aches on June 11, 1979. He was on therapeutically prescribed Valium (diazepam) 10 mg tid and Darvon (Propxyphene) 65 mg tid, for the last 8 and 6 years, respectively, but due to their apparent ineffectiveness, he had discontinued them 3 weeks prior to this hospitalization. There was no past history of hallucinations and seizures, and he was not known to abuse any other drug including alcohol, as confirmed by his wife.

* Dr. Chandora is Assistant Clinical Professor at the Medical College of Georgia. His address is VAMC, Lenwood Division, Medical College of Georgia, Augusta,GA 30904.

He was observed, investigated, and evaluated, without administration of psychotropic medication for 2 weeks. During this period, his psychomotor activity and behavior were appropriate, but mild depression and anxiety were observed.There was no evidence of organicity and psychosis. His ability to fall asleep and to attain sleepstate deteriorated gradually due to frequent wake up periods, 4-6 per night. He was not found to sleep in the daytime.

Two weeks after admission, that is, 5 weeks after discontinuation of medication, his total sleep time was shortened, and he would remain awake most of the night. He became excited, irritable, and talked to himself. His condition became worse during the fourth week of his hospitalization (7 weeks after stopping diazepam). He did not sleep for 3-4 days at a time and was found having auditory and visual hallucinations. He experienced a generalized convulsion and fell out of his chair. Postictally he was confused, incoherent in speech and had jerky abnormal movements of hands as if climbing a rope; 120 mg of phenobarbitol intramuscularly sedated him. Eight hours later when he awakened, his hallucinations were: "Seeing a murder in a square." The night physician ordered chlordiazepoxide 25 mg po to sedate. In the morning, he was somewhat drowsy and ataxic, though oriented, coherent, and slightly agitated. He complained of soreness all over his body. This time diazepam withdrawal was considered and 10 mg of diazepam was given (i.e. 12 hours after chlordiazepoxide). Two hours later he was quiet, cooperative, and showed good adjustment in reality testing and insight. The next day, hallucinations and confusion disappeared. His appetitite im-

proved, and he was able to sleep. Initial starting dose of diazepam was 10 mg hs and then reduced to 5 mg. Slowly it was tapered off to every other day and then discontinued. Diagnostic work-up for brain tumor was negative and when last contacted 7 months later, in January 1980, he showed no further problem.

Comments

In this patient, withdrawal symptoms such as auditory and visual hallucinations, agitation, marked insomnia, confusion, and convulsions started five weeks after cessation of 8 years of a low dose of diazepam therapy. Auditory hallucinations as observed have not been reported earlier.[1-4] The complete resolution of this state to normality by therapeutic intervention with chlordiazepoxide and diazepam, is in accordance with the experience of Floyd and Murphy who reported similar responses.[3]

One might consider psychotic depressive reaction and propoxyphene withdrawal to alter a patient's physical and mental status. The presence of confusion and convulsions and the clinical picture do not support psychotic depressive reaction. Propoxyphene withdrawal symptoms appear abruptly within 24-72 hours of discontinuation when its intake exceeded many times the prescribed therapeutic dose, usually above 1000 mg a day.[6,7] They consist of dilated pupils, goosefleshings, tremor, recurrence of original pain and cramps. Hence, the question of propoxyphene withdrawal does not arise. The dramatic response within hours of chlordiazepoxide and diazepam seem to confirm this as a withdrawal reaction to diazepam.

This patient's mental changes developed 5 weeks after discontinuation of diazepam, and the immediate resolution within hours of therapeutic intervention seem to confirm this as a delayed withdrawal syndrome.

Discussion

Withdrawal symptoms have been known to occur between 2-12 days (average 8 days) after discontinuation of diazepam. Hallucinations and seizures have followed after abrupt stoppage of diazepam.[1,3] The surge of such symptoms after a latent period of 5 weeks abstinence, as happened in this case, has not been reported. The occurrence of convulsions and confusion suggests that a state of physical dependence had developed. In addition, a state of psychological dependence was indicated by excitement, hallucinations, marked insomnia, and agitation developing in the withdrawal phase. Thus, one can conclude that physical and psychological dependence has developed in this case after prolonged use of diazepam, though in small doses.

Over 460 million prescriptions have been written for propoxyphene products since their introduction in 1957. Published studies show its dependence potential, and withdrawal symptoms do occur when chronic use of large doses is abruptly stopped.[6, 7] This patient's mental changes are not consistent with the reported withdrawal effects of propoxyphene.

Severe withdrawal symptoms were known to be associated with long periods of use and high doses.[1, 5] But in this case, prolonged use appeared to be more important than the magnitude of dose in causing the withdrawal syndrome.

Acknowledgment

The author wishes to thank S. K. Tikare, M.D., Internist, VAMC, Augusta, GA for help in preparing this manuscript.

References

1. DeBard ML. Diazepam withdrawal syndrome. Am J Psy 1979; 136:104-105.
2. Maletzky BM, Klotter J. Addiction to diazepam. Int J Addict 1976; 11:95-115.
3. Floyd JB Jr., Murphy CM: Hallucinations following withdrawal of Valium. J Ky Med Assoc 1976; 74(11):549-550.
4. Hollister LE (Ed). Valium, a discussion of current issues. Psychosomatics 1977; 18:1-58.
5. Editorials: Benzodiazepines: dependence and withdrawal. JAMA 1979; 242-1401.
6. Maletzky M. Addiction to propoxyphene, a second look. Int J Addict 1979; 9:775-784.
7. Bennett IF. Personal Communication. Lilly Research Laboratories Aug. 22, 1979.

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.





Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8—5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10—20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq o elemental potassium. The usual preventative dose of potassium 20 mEq per day while therapeutic doses range from 30 mEq t 100 mEq per day. Because of the potential for gastrointestin irritation, undiluted large single doses (30 ml or more) or TWIN- are to be avoided.

Deviations from this schedule may be indicated, since no averag total daily dose can be defined, but must be governed by clos observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescrip tion.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the followin ingredients:

Pentylenetetrazol	30 m
Niacin	50 m
Vitamin B-1	10 m
Vitamin B-2	5 m
Vitamin B-6	1 m
Vitamin B-12	3 mc
Choline	100 m
Inositol	50 m
Manganese (as Manganese Sulfate)	1 m
Magnesium (as Magnesium Sulfate)	2 m
Zinc (as Zinc Sulfate)	1 m
Iron (as Ferric Pyrophosphate, Soluble)	22 m
Alcohol	18'

INDICATIONS AND USAGE: SU-TON contains pentylenetetraz which may be helpful in the older patient as an analeptic age when mental confusion and memory defects are present. SU-TO also contains vitamins, trace minerals, and iron, for those patien who may benefit by preventing the development of a deficienc

CONTRAINDICATIONS: Epilepsy, convulsive disorders or know history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy an lactation has not been established. Use of this drug requires tha the physician evaluate the potential benefits of the drug again any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindic tions to pentylenetetrazol, it should be used with caution epileptic patients or those known to have a low convulsiv threshold or a focal brain lesion. Caution should be exercise when treating patients with high doses of SU-TON who have hea disease. While pentylenetetrazol does not act directly on th myocardium, the results from central vagal stimulation coul cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses ma produce toxic symptoms typical of central nervous syste stimulants, which act on the higher motor centers and the spin cord. Convulsions resulting from this drug are spontaneous ar are not induced by external stimuli. They usually last for sever minutes and are followed by profound depression an respiratory paralysis. Death has been reported from the ingestic of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported wi SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may b due principally from overstimulation of the central nervo system and from excessive vasodilatation with resultir autonomic nervous system imbalance. The symptoms may includ the following: vomiting, agitation, tremors, hyperreflexia, swea ing, confusion, hallucinations, headache, hyperpyrexi tachycardia. Treatment consists of appropriate supporti measures. If signs and symptoms are not too severe and th patient is conscious, gastric evacuation may be accomplished b induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circul tion and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (15 ml) times a day 20-30 minutes before meals. This drug is not for use children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-0015-

CAUTION: Federal law prohibits dispensing without a prescri tion.

AP-001 5-80 Printed in U.S

NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

First Class Permit No. 1563, Shreveport, LA.

Postage will be paid by addressee

BOOTS PHARMACEUTICALS, INC.

Department 0
6540 Line Avenue
Shreveport, LA. 71106

BOOTS PHARMACEUTICALS INC.

Shreveport, Louisiana 71106

Pioneers in medicine for the fam

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

R ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

CHOPPER ONE



CU 101



SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO

AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

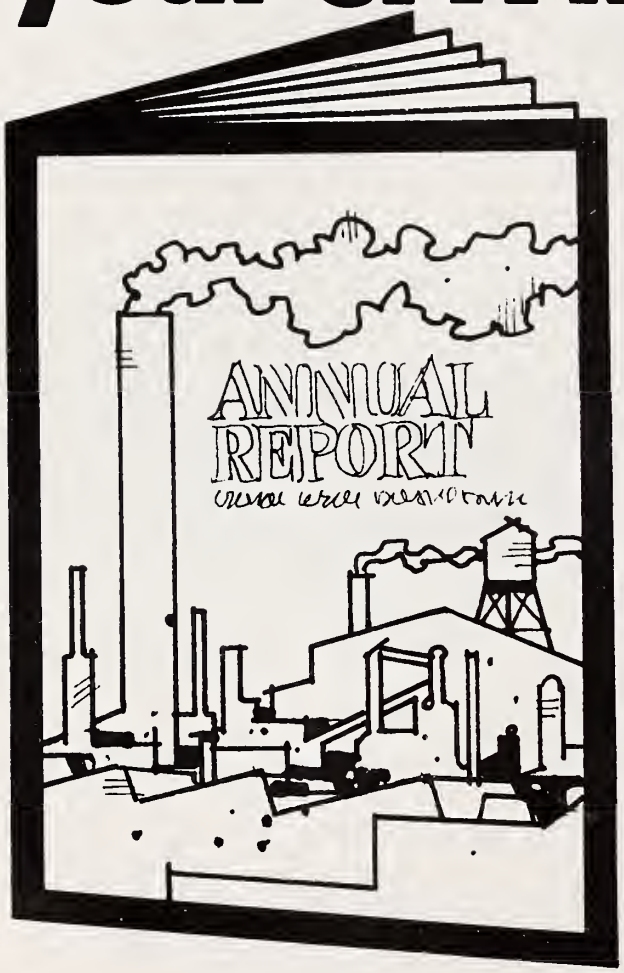
Any Patient — Any Equipment Anytime

—— **CALL TOLL FREE** ——

ORGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763

how do others make more profits? your CPA knows.



Financial structuring, budgeting and forecasting, and short and long range planning are just a few of many services performed by Certified Public Accountants (CPAs) that can prove profitable whether you are a one man operation, partnership, or corporation. In the process of auditing, CPAs scrutinize your internal control systems, cash flow, depreciation of assets, securities, inventory valuations, contracts, leases, insurance, tax reserves, and related information concerning your financial position and operating results.

Certified Public Accountants are professionals authorized by law to perform the full range of accounting services. For help in increasing your profitability consult the Yellow Pages under "Accountants—Certified Public."

Ask a CPA, and be sure

CPA

Georgia Society of Certified Public Accountants

6403

Echocardiography — Its Usefulness and Limitations

MILTIADIS A. STEFADOUROS, M.D., *Augusta**

ECHOCARDIOGRAPHY was first used in the early 1950s as a crude method of visualizing the mitral valve and has since been developed into a highly sophisticated and indispensable diagnostic tool. The obvious attraction of echocardiography as a harmless, easy to repeat, and relatively inexpensive technique, coupled with an ever-expanding spectrum of diagnostic applications, has resulted in its immense popularity. In most institutions, the frequency of it use is second only to that of electrocardiography.

Echocardiography is an excellent method for detecting **mitral stenosis.** It provides useful information as to the pliability and calcification of the stenotic mitral valve and thus facilitates the decision for the most appropriate surgical management — such as commissurotomy or valve replacement. Yet, despite initial claims to the contrary, the problem of reliable assessment of its severity remains unsolved[1] and experience from the use of cross sectional echocardiography to this end permits a certain degree of optimism.[2] In contrast to stenosis, **mitral regurgitation** presents no pathognomonic echocardiographic feature, except when it is due to such conditions as prolapsed mitral valve or flail mitral leaflet. However, strong evidence for its presence and a rough quantitation of its severity can be provided by the increased dimensions and exaggerated wall motion of the left ventricle and atrium and by the presence of premature systolic closure of the aortic valve.

Prolapsed mitral valve is easily detected if strict echocardiographic diagnostic criteria are adhered to, thus eliminating the chance for false-positive results. The detection of **mitral valve vegetations** of bacterial endocarditis is not as easy, and this is true for other valves as well, unless the vegetations are large enough (> 4-5 mm) to be detected with some degree of confidence. Under no circumstances, therefore, should a clinically suspected diagnosis of bacterial endocarditis be ruled out on the basis of a negative echocardiographic search for vegetations. Repeat studies done a few days later are valuable, since they frequently reveal the existence of vegetations when compared to the initial negative or inconclusive echogram. **Flail mitral leaflets** due to rupture of the chordae tendinae or the papillary muscle are recognized by the characteristic distortion of their pattern of motion and position throughout the cardiac cycle and by their abnormal appearance deep into the left atrium in systole. Thus, in the patient who presents with significant clinical deterioration and a new apical holosystolic murmur following a myocardial infarction, important diagnostic and prognostic information may be provided by establishing or excluding the presence of flail mitral valve by echocardiography.

Dr. Stefadouros is Associate Professor of Medicine and Director of the Cardiac Noninvasive Laboratory, Section of Cardiology, Department of Medicine, Augusta 30912. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Stefadourous, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

Although anatomic abnormalities of the aortic valve are easily detectable by echocardiography, evaluation of their functional importance is far from easy. Thus, a distorted, thickened, occasionally calcified aortic valve echogram with limited systolic leaflet excursion may occasionally be associated with only mild **aortic stenosis.** In other patients, there may be severe aortic stenosis when the echogram showed only modest distortion of this valve. A good estimate of the severity of aortic stenosis can be made from the end-systolic left ventricular (LV) wall thickness/cavity dimension ratio measured on the M-mode echogram.[3] **Bicuspid aortic valve** is recognized by its eccentric diastolic position within the aortic lumen, but **congenital aortic stenosis** with a noncalcified, unicuspid, dome-shaped aortic valve, may evade detection by M-mode echocardiography even when severe. Cross sectional echocardiography, by virtue of its expanded two-dimensional view, is better able to evaluate aortic **valvular, subvalvular,** and **supravalvular stenosis.**

In **aortic regurgitation,** the aortic valve echogram may be normal or may present excessive (> 5 mm) diastolic separation and fine, fluttering motion of the aortic leaflets. In most cases, however, the aortic echogram is abnormal in a nonspecific way, resembling that obtained in aortic stenosis with which it frequently co-exists. A rather specific sign of aortic regurgitation is fine, high frequency diastolic motion affecting usually the anterior mitral cusp, occasionally the left side of the septum, or both. Except in acute aortic regurgitation, the LV diastolic dimension is a crude measure of the magnitude of the leak.

Detection of **aneurysms of the ascending aorta** is not difficult, but identification of **dissection of the aortic wall** can be unless meticulous attention is paid to technical details.

Hypertrophic cardiomyopathy is another disease with several echocardiographic features such as asymmetrical hypertrophy (ASH) and diminished motion of the septum, small LV cavity and outflow dimensions, left atrial enlargement, abnormal systolic anterior motion of the mitral valve (SAM), transient mid-systolic aortic valve closure, and increased LV performance indices. Of these, SAM has been shown to provide a useful marker of the presence and severity of obstruction.[4] Although common, ASH is not a feature unique to this disease, since it has been observed in conditions representing pressure overloading of either the left (systemic hypertension, aortic stenosis) or the right ventricle (pulmonary hypertension, pulmonary stenosis).

Echocardiographic examination of the left ventricle permits identification and quantitation of its size, hypertrophy, and overall function. From these data, valuable conclusions can be drawn concerning the hemodynamic severity of underlying lesions. With regard to LV function, errors are likely to occur in patients with regional abnormalities in LV wall motion mostly due to **coronary artery disease.** In such cases, cross sectional echocardiography is useful, for it permits direct identification of the location, extent, and severity of the wall dyssynergy, and detection of possibly co-existing, sizable mural or intracavitary thrombus.

The echocardiographic examination of the valves and cavities of the right side of the heart, although somewhat more difficult than that of the left side, should always be attempted. **Tricuspid stenosis** presents echcardiographic features similar to those of the stenotic mitral valve. **Tricuspid regurgitation** has no pathognomonic findings but, except when mild, may be suspected from the increased right ventricular cavity dimensions and paradoxical septal motion it produces. This combination is common to several other conditions, most of which represent isolated right ventricular volume overloading, such as **atrial septal defect (ASD), partial anomalous pulmonary venous drainage** into the right atrium, and **pulmonary valve regurgitation.** In addition, the tricuspid valve echogram may present evidence of **Valsalva sinus aneurysm** ruptured into the right side of the heart. **Prolapsed tricuspid valve** and **tricuspid valve vegetations** of bacterial endocarditis distort the echogram of this valve in a way similar to that observed in mitral valves.

In the presence of sinus mechanism, **pulmonary hypertension** of any etiology results, among other things, in a decrease in amplitude of elimination of the atrial "a" wave of the pulmonary valve echogram, whereas **valvular pulmonary stenosis** has exactly the opposite effect, namely, an increase in the relative and absolute amplitude of this wave. Unfortunately, the pulmonary valve echogram is unobtainable in many adult patients.

Echocardiography remains unsurpassed by any other noninvasive method in its capability to detect **pericardial effusion,** even in minute amounts, and to provide a rough estimate of the amount of effusion as small (< 100 ml), moderate (100-500 ml), and large (> 500 ml).[5] In addition, identification of **pericardial thickening** and **constrictive pericarditis** is possible but requires considerable expertise and high quality M-mode echogram.[6]

Atrial tumors — mostly myxomas — and **mural or intracavitary thrombi** can be detected by M-mode and/or cross sectional echocardiography within either atrium. Because these often disabling and possibly fatal masses can be removed surgically, the echocardiographic examination of the atrium is mandatory in the evaluation of the patient with physical signs and/or symptoms suggestive of fixed or intermittent obstruction of either atrioventricular valve.

Of the congenital cardiac abnormalities commonly found in adults, echocardiography can only provide supportive by not definitive evidence of clinically suspected ASA, **ventricular septal defect (VSD),** and **patent ductus arteriosus (PDA).** ASA and VSD, complicated by severe pulmonary hypertension with reversed right-to-left shunt, can be identified by the abnormal visualization of the cardiac chambers by an echo-producing indicator (saline, cardiogren) injected into a peripheral vein ("contrast echocardiography"). M-mode echocardiography may be used to diagnose **Ebstein's anomaly, Fallot's tetralogy, tricuspid atresia, transposition of the great vessels,** and **single ventricle.** These and other more complex congenital cardiac abnormalities, however, are better evaluated by cross sectional echocardiography.

References

1. Cope GD, Kisslo JA Johnson ML, Behar VS. A reassessment of the echocardiogram in mitral stenosis, Circulation 1975; 52:664.
2. Henry WL, Griffith LM, Michaelis LL, McIntosh CL, Morrow AG, Epstein SE. Measurement of mitral orifice area in patients with mitral valve disease by real-time, two-dimensional echocardiography, Circulation. 1975; 51:827.
3. Bennet DH, Evans DW, Raj MVJ. Echocardiographic left ventricular dimensions in pressure and volume overload. Their use in assessing aortic stenosis. Brit Heart J 1975; 37:971.
4. Gilbert BW, Pollick C, Adelman AG, Wiegel ED. Hypertrophic cardiomyopathy: Subclassification by M-mode echocardiography. Am J Cardiol 1980; 45:861.
5. Horowitz MS, Schultz CS, Stinson EB, Harrison DC, Popp RL. Sensitivity and specificity of echocardiographic diagnosis of pericardial effusion. Circulation 1974; 50:239-247.
6. Schnittger I, Bowden RE, Abrams J, Popp RL. Echocardiography: Pericardial thickening and constrictive pericarditis. Am J Cardiol 1978; 42:388-395.

editorial
editorial
editorial

On Medical Ethics

The article, "State-Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgement," in the April issue of the *Journal of the Medical Association of Georgia* is both cogent and timely. The author emphasizes the judicial dependence upon physicians for medical judgment.[1] The full importance of a physician's responsibility in abortion and other ethical issues must not be passed over, but needs to be explored.

First, the distinction between individual and group responsibility must be made. Ethically, responsibility can never be placed on a group. An individual may choose to adopt the standards of a group as his own, e.g., the AMA Code of Ethics, but he remains responsible morally for that decision. Individuals have consciences, not groups. Moral decisions cannot be shifted from an individual because he is a member of a group.

A moral consideration in addition to the particular issue concerns the individual's responsibility to reflect his moral stance as a member of the group; in this instance, the medical profession. A physician's opinion or vote or the failure to participate in the group process (for whatever the reason) also has moral implications. Thus, the physician is morally responsible in medical decisions regardless of his involvement or non-involvement in the group position. One is not absolved by avoiding the issue.

Second, the distinction must be made between legality and morality. Ethical standards, e.g., the Hippocratic Oath, are developed and stand apart from the legal system. To justify abortion or anything else because it is legal is an error of judgment. In the Judeo-Christian tradition, God's laws stand above men's laws, and men are responsible to the legal system only as that system accurately reflects God's laws. This is the heart of the current issue about whether physicians should participate in capital punishment.[2] To justify abortion because it is legal is to justify physician participation in capital punishment because it is also legal.

Third, ethical decisions are always an appeal to a standard or code which may include a popular ethicist, medical code of ethics, a governing board, or a religion. Thus, the decision is only valid to the extent that the philosophical base of the standard is true. Therefore, one must thoroughly evaluate that philosophical base to be sure of its being authoritative and reliable, especially concerning life and death issues.

Fourth, in the immediate issue of abortion, the reasons for its practice must be examined. With modern technical and medical capability, a mother's life is rarely threatened physically; moreover, rape and incest are rarely a cause of pregnancy. Thus, in reality, the great majority of abortions are performed because of emotional, psychological, familial, and personal factors. To state this representation in another way is to say that motherhood now represents "mental illness" in those cases of pregnancy which are aborted for these reasons. Perhaps we should re-examine such a definition of mental illness which would so profane what was (and still should be) considered sacred.

Finally, in the "Bible belt" we must be careful that Biblical standards are represented. The thinking that something does not exist because it cannot be

scientifically investigated is subtle but powerful. The spiritual exists beyond scientific investigation, but the spiritual is no less real because of this fact. Large numbers of physicians (and others) with these convictions would decidedly agree. These physicians must speak to that reality which itself speaks clearly to many ethical issues in espousing the sanctity of life.

Other concepts could be further developed; these have been presented here as food for serious thought. No greater issues face the medical profession. We must be careful in our thinking and aware of the moral implications of our decisions. Our judicial system has clearly placed the responsibility for medical decisions upon the profession as a group and as individuals. Morally, those decisions have always been ours. Abortion is here. Euthanasia is beginning to be acted upon by the courts.[3] Just this year, legislation was introduced in Georgia concerning euthanasia (Right to Die Bill). Such legislation is dangerous because of the unique nature of individual cases.[4] Surely physicians will assume their rightful responsibility to stop, and perhaps reverse, the tide against respect for human life because it is not of some ill-defined "quality". The individual responsibility is ours whether we want it or not.

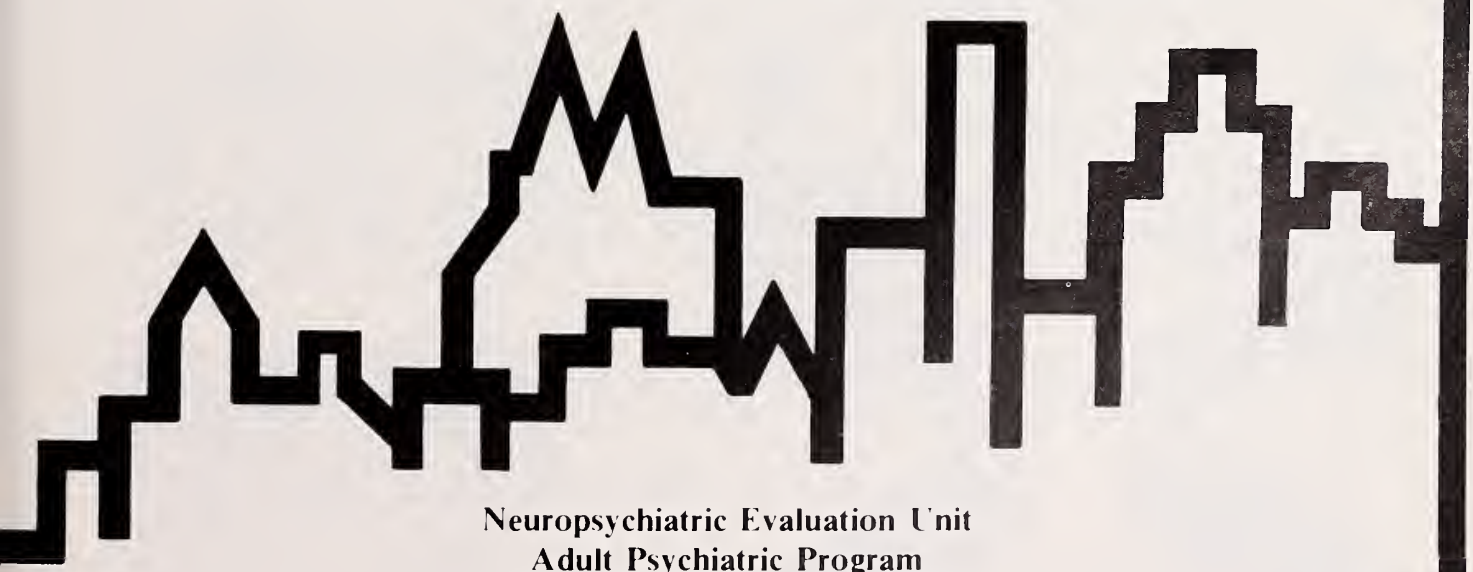
F. Edward Payne, Jr., M.D.
Augusta

[Editor's Note: Other legal aspects regarding the issue of abortion are discussed in this month's "Legal Page."]

References

1. Harper TD. State-funded abortions: judicial acquiescence in the sanctity of a physician's medical judgment. J Med Assoc of Ga 1980; 69:313-315.
2. Curran WJ, Cascells WC. The ethics of medical participation in capital punishment by intravenous drug injection. N Engl J Med 1980; 302:226-230.
3. Will GF. The case of Phillip Becker. Newsweek April 14, 1980.
4. Koop EC. Right to live, right to die. Wheaton: Tyndale House, 1976.

Psychiatric Institute of Atlanta
Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

Remember

ZYLOPRIM®

the original (allopurinol)

100 and 300 mg

Scored Tablets

The name Zyloprim is now imprinted on each tablet.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®



8-3305 (Y371A)



Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

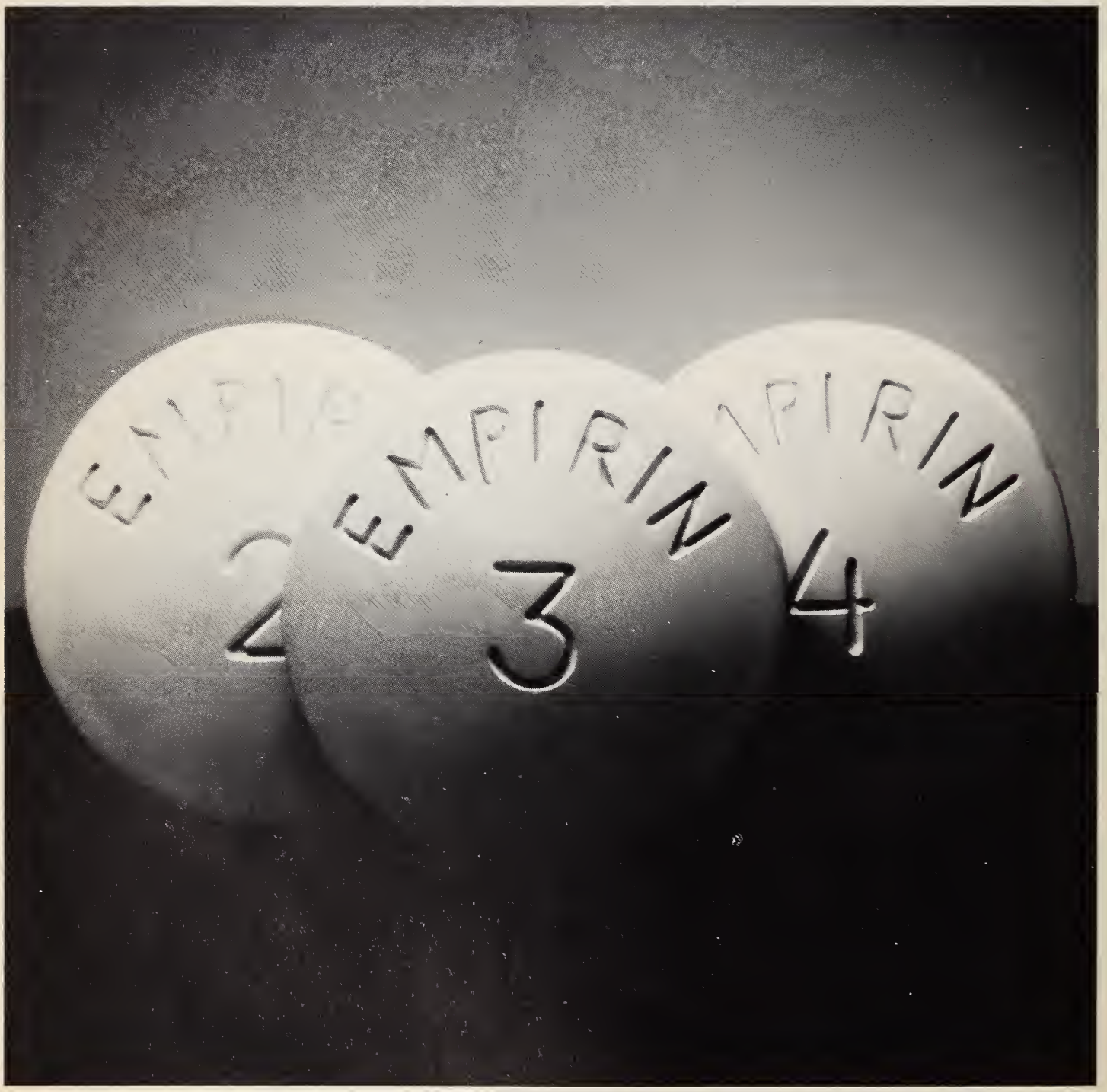
See opposite page for prescribing information.

AS CLOSE AS A CLASSIC CAN COME TO THE FUTURE.

Aspirin and codeine. Classic agents whose respective roles in medicine continue to be developed. Empirin® c̄ Codeine. An impressive history and an important future.

EMPIRIN® c̄ CODEINE

Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: No. 2—15 mg, No. 3—30 mg, and No. 4—60 mg. (Warning—may be habit-forming.)



ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Recent Developments in the Health Care Area

THOMAS D. HARPER and ROBERT N. BERG, *Atlanta**

RECENTLY, there have been several court decisions of significance in the health care area. In one case which received a substantial amount of publicity, the United States Supreme Court was faced with the question of whether or not states were required to fund abortions under the Medicaid program. In a second, less-publicized case, a lower court was required to determine whether a Professional Standards Review Organization (PSRO) was a federal agency subject to the disclosure requirements of the federal Freedom of Information Act. Both of these issues are discussed in the following text.

State and Federal Governments Are Not Obligated to Fund Abortions

The United States Supreme Court has authoritatively and conclusively established that a woman has no constitutional right to a state or federally funded abortion. In so doing, the Supreme Court resolved several contrary lower court rulings and extended Congressional power to limit the expenditure of federal funds.[1]

As discussed in previous "Legal Pages,"[2] Congress has established, by a funding exclusion commonly referred to as the "Hyde Amendment," a limitation upon the expenditure of federally appropriated funds provided pursuant to Title XIX of the Social Security Act ("Medicaid"). This exclusion was held by a United States District Court in Georgia[3] not to affect a state's duty to fund abortions deemed to be "medically necessary." A United States District Court in New York[4] held the Hyde Amendment to be unconstitutional for failing to require funding of abortions that were deemed "medically necessary."

Contrary to the Georgia Court's ruling, the United States Supreme Court determined that the Medicaid program provides no unilateral funding obligation for a state which chooses to participate in the system. Medicaid was intended to be a cooperative program of shared financial responsibility; it is not a device to compel a state to provide services which Congress is unwilling to fund.

Contrary to the New York Court's ruling, the United States Supreme Court concluded that the Hyde Amendment is not constitutionally deficient. First, the Supreme Court determined that a restriction upon the availability of state-funded abortions is not an infringement upon individual liberty under the Due Process Clause of the United States Constitution. Although the Supreme Court has previously recognized a right of free choice in abortion decisions, "it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices."

* Prepared at the request of the Medical Association of Georgia. Messrs. Harper and Berg are associates in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

The fact that a state may not prohibit a certain activity does not give rise to an affirmative constitutional obligation to insure that all persons have the financial resources to avail themselves of those choices.[5]

Second, the Supreme Court determined that the limitation of abortion funding does not constitute a violation of the Establishment Clause of the First Amendment. The Establishment Clause prohibits the "establishment" of a state religion. This provision is not infringed where the legislation at issue has a secular purpose whose principal effect is not to advance or inhibit religious expression.

Third, in the Supreme Court's opinion, the limitation upon funding does not constitute a violation of the Equal Protection Clause of the Fourteenth Amendment. The Equal Protection Clause has been interpreted as establishing a right to freedom from "invidious discrimination" in legislative classifications, but financial need alone does not identify a suspect class sufficient to require more than a rational relation to a legitimate government purpose. The Court recognized a legitimate government purpose in the protection of the potential life of the fetus. Congress is permitted to implement this legitimate interest by making childbirth a more attractive alternative to abortion by funding the expense of childbirth but not the expense of an abortion.

The Supreme Court's recent pronouncements on abortion have established that women have a right to terminate a pregnancy during the initial term of gestation. The absolute right is lost as the fetus develops, but a woman's physician, in consultation with his or her patient, retains the right to determine, in the exercise of his or her best medical judgment, whether or not the pregnancy should be terminated by an abortion. The physician's decision is not limited by physiologic factors, but includes emotional, psychologic, and familial factors impacting on the woman's overall well-being.

Counterpoised against these decisions is the rule that state and federal governments are not obligated to finance abortions for individuals who qualify for Medicaid assistance. Although the United States Congress may, if it chooses, pay for abortions, there is not a constitutional requirement for the use of Medicaid funds for abortions.[6] The United States Supreme Court has simply stated that although there is a constitutional right to have abortions available, there is no constitutional right to the funding of the exercise of that right.

[Editor's Note: See the "Editorial" in this month's issue for an interesting discussion of some of the ethical considerations that face physicians concerned with abortions.]

Disclosure of PSRO Records under the Freedom of Information Act

A second recent development of significant import in the health care area concerns the question of whether a PSRO is subject to the disclosure requirements of the federal Freedom of Information Act (the FOI Act).

This question was first encountered by the courts in a case in 1978 arising in the District of Columbia.[7] In that case, a non-profit research organization engaged in consumer advocacy sought certain information and documents from the PSRO for the District of Columbia. Faced for the first time with the question of whether or not a PSRO is an "agency" within the terms of the FOI Act (and thus subject to the FOI Act's disclosure requirements), the District Court determined that the PSRO was clothed with "indicia of agency status" and was therefore an "agency" within the meaning of the FOI Act. Its decision was based upon the facts that the PSRO was financed by the federal government, was a creature of federal statute, performed executive functions and operated under direct, pervasive, continuous regulatory control effecting even minutia of its procedures and functions.[8]

As might have been expected, this decision caused quite a furor among both the numerous PSROs and among the persons and institutions providing information

and records to those entities. In fact, legislation was introduced in Congress specifically to negate by statute the court's opinion in the *Public Citizen* decision.[9]

Recently, however, the United States District Court for the Eastern District of Pennsylvania, in an unpublished decision, refused to find that a PSRO was an "agency" within the meaning of the FOI Act.

In *St. Mary Hospital v. Philadelphia Professional Standards Review Organization, Inc.*,[10] a local Philadelphia hospital brought an action under the FOI Act to compel the defendant PSRO to grant to the hospital access to a voluminous amount of documents and records, including documents involving all of the area hospitals monitored by the PSRO. The plaintiff hospital relied heavily on the earlier *Public Citizen* case in support of its position that the defendant PSRO was a federal agency within the meaning of the FOI Act.

The District Court disagreed, however, holding that the PSRO was *not* an "agency" within the meaning of the FOI Act and was thus not subject to the disclosure requirements of that Act.

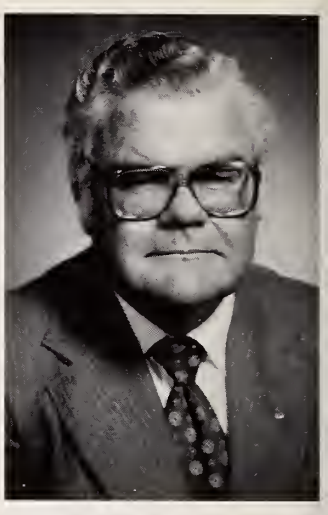
In support of its decision, the Court relied heavily on the legislative history surrounding the promulgation of the PSRO Statute which in the eyes of the Court indicated that Congress intended PSROs to be private, non-governmental bodies. Additionally, the Court relied on a recent Supreme Court decision, *Forsham v. Harris*,[11] decided subsequent to the *Public Citizen* decision. The *Forsham* case involved an attempt to obtain information and records belonging to a group of private physicians and scientists conducting diabetes research. Despite the fact that this research group received substantial funding from the then Department of Health, Education, and Welfare and was supervised to a certain extent by HEW, the Supreme Court held that, absent "extensive, detailed, and virtually day-to-day supervision" by the federal government of the activities of a private organization which receives federal funds, such an organization cannot be considered a governmental entity.

Applying the Supreme Court's decision in the *Forsham* case to the facts in the *St. Mary Hospital* case, the District Court determined that the PSRO was not subject to the day-to-day supervision of the federal government and was thus not an "agency" within the meaning of the FOI Act. Accordingly, even though the PSRO was created by federal statute, received substantial funding from the federal government, and was subject to "pervasive federal regulatory control," the District Court found that it was not an "agency" because the day-to-day administration of the PSRO remained in the hands of the organization itself.

NOTES

1. *Harris v. McRae*, 48 U.S.L.W. 4941 (June 30, 1980).
2. Harper TD. "State Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgment," JMAG 1980; 69(4), 313. April.
3. *Doe v. Busbee*, 471 F. Supp. 1326 (N.D. Ga. 1979).
4. *McRae v. H.E.W.*, No. 76-C-1804 (E.D.N.Y. January 15, 1980).
5. *Harris v. McRae, supra*, 48 U.S.L.W. at 4947.
6. See, *Maher v. Roe*, 432 U.S. 464 (1977).
7. *Public Citizen Health Research Group v. Department of Health, Education and Welfare*, 449 F. Supp. 937 (D.D.C. 1978).
8. For a more detailed treatment of the *Public Citizen* decision, see Berg, RN, "Release of PSRO Data to the Public Under Federal Law," *JMAG*, August, 1978.
9. See, Berg, RN, "Recent Developments: . . . Congress Reacts to Adverse Disclosure of PSRO Information Decision," *JMAG*, October, 1978. These legislative bills were ultimately not passed by Congress.
10. Civil Action No. 78-2943 (D.C.E.D.Pa., June 25, 1980).
11. _____U.S._____, 100 S.Ct. 978 (1980).

president's letter



A Beautiful Partnership

OTHER THAN the MAG, nobody in Georgia does more to protect and promote the interests of patients and physicians than the Auxiliary to the Medical Association of Georgia. Every physician benefits from the activities of this group.

My observation is that our Auxiliary generates positive emotions. These positive emotions create a partnership with our physicians that produce information. Information is the key to proper functioning. Proper functioning brings results.

The Auxiliary activates facts, and facts provide structure.

Under the outstanding leadership of Mrs. Milton B. (Ann) Satcher of Atlanta during 1980-1981, the Auxiliary aims include:

1. Communications programs to inform the public on health care matters.
2. The promotion of P.R.I.D.E. (Parents' Resource Institute for Drug Education), a dominant health education project.
3. Dedicated and willing assistance to *all* facets of our Disabled Doctor's Program.
4. Financial contributions to AMA-ERF. From 1975 to 1980, the Auxiliary has contributed $57,000.00 to this project.
5. Strong support and assistance in all MAG legislative efforts.
6. Many other involvements always aimed toward supporting the medical profession.

Our Auxiliary is actively helping to create the voluntary climate in which medicine and health care function most successfully.

This partnership of the Auxiliary and the MAG is essential. It produces a balance for which Georgia physicians are grateful, appreciative, and indeed, indebted.

Respectfully,

H. Hilt Hammett Jr., M. D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

NEW MEMBERS

Ahrano, Judith, Stephens-Rabun — N-2 — PD
800 E. Doyle St., Toccoa 30577

Allen-Dalrymple, Barbara J., Jackson-Banks — N-2 — OBG
Hospital Rd., Commerce 30529

Chen, Yee Chon, Clayton-Fayette — ACT — ORS
150 Medical Way, Ste. B., Riverdale 30274

Cuff, John V., Crawford W. Long — N-2 — NS
1010 Prince Ave., Athens 30606

Goldstein, Joel A., Clayton-Fayette — ACT — PD
29 S.W. Upper Riverdale Rd., Riverdale 30274

Herskowitz, Louis J., MAA — I&R —
2615 Indian Lake Dr., Marietta 30062

Jung, Hee C., Clayton-Fayette — ACT — AN
409 Arrowhead Blvd., Bldg. A, Jonesboro 30236

McConnel, Fred M. S., DeKalb — ACT — HNS
1365 Clifton Rd., NE, Atlanta 30322

Petry, Gary L., MAA — ACT — OM
2000 Northeast Expy., Norcross 30071

Shetty, Yeshwanthi, DeKalb — ACT — P
2531 Briarcliff Rd., Ste. 216, Atlanta 30329

Smith, Sarah C., Cobb — N-2 — R
600 W. Memorial Dr., Dallas 30132

PERSONALS

First District

Ashburn Mayor J. I. Youngblood proclaimed Friday, June 27, as **Dr. C. C. Goss** Day in Ashburn to pay tribute to his 32 years of service to Turner County. Dr. Goss retired July 1.

James I. Scott, M.D., general and vascular surgeon, recently opened his practice in Savannah.

David E. Tanner, M.D., Savannah, was recently selected for Fellowship in the American College of Radiology.

The Yeh Zipper Club had its first meeting June 28 at Bryant's Kitchen in Statesboro. Members of the club are those former patients of **Thomas J. Yeh, M.D.,** Savannah surgeon, who have been "patched, plugged, prodded, paced, by-passed, left in stitches, and otherwise delivered from comeuppance in the last decade. . . . " (So read the invitation to the meeting.)

Second District

Stephen C. Allen, M.D., urologist, has opened his practice in Moultrie.

Gerald N. Kadis, M.D., a neurosurgeon at the South Georgia Neurological Institute in Thomasville, spoke to the Rotary Club of Moultrie. Through the use of slides and videotape cassettes, Dr. Kadis demonstrated the removal of brain tumors, ruptured discs, and other ailments of the nervous system.

Fourth District

Stanley W. Sherman, M.D., Decatur, was recently named a Fellow in the American College of Cardiology.

M. Virginia Tuggle, M.D., of Decatur, was elected President of the Composite State Board of Medical Examiners, succeeding J. Duncan Farris, M.D., of Waycross. Dr. Tuggle is the first woman to serve on the 10-member panel.

Fifth District

Ernest Franklin, M.D., of Duluth, and **David Stacy, M.D.,** of Dunwoody, were named Nurse Recruitment Fellows at St. Joseph's Hospital in Atlanta. The doctors were honored for their efforts to attract new nursing candidates to the hospital.

Cosmo L. Haun, M.D., and **Paul A. Lavietes, M.D.,** of Atlanta, were selected for Fellowship in the American College of Radiology.

John W. Hurst, Jr., M.D., Atlanta, was named a Fellow in the American College of Cardiology.

Sixth District

P. Denis Gauthier, M.D., Jeffersonville, graduated from The Woodrow Wilson College of Law with the Juris Doctor Degree on June 14.

John Hudson, M.D., of Macon, has recently been appointed Chief of Medicine and Assistant Director of the Department of Medical Education at the Medical Center of Central Georgia.

Michael T. Simpson, M.D., LaGrange, was named a Fellow in the American College of Cardiology.

Seventh District

Herschel U. Martin, M.D., Dalton, was selected for Fellowship in the American College of Radiology.

Klaus O. Rees, M.D., Lithia Springs, was named a Fellow in the American College of Cardiology.

Lucius Smith, M.D., Rome, was recently elected president of the Floyd Medical Center at the Center's

annual meeting. **Edward Brewster, M.D.,** was named secretary. **L. C. Rigas, M.D.,** also of Rome is the immediate past president.

Richard Young, M.D., opened his pediatrics practice in Cartersville on July 10.

Eighth District

On June 26, The Exchange Club of Appling County honored **James A. Bedingfield, M.D.,** Baxley, for his service to the County. Dr. Bedingfield was presented the Book of Golden Deeds award.

SOCIETIES

Charles Edwin Nuttall, Jr., M.D., Rome, medical director of the Northwest Georgia Dialysis Facility, spoke to the Gordon County Medical society at their June 30 meeting. His subject was "Dialysis in Northwest Georgia."

DEATHS

H. J. Copeland

H. J. Copeland, M.D., 79, of Griffin, died June 30 at his summer home in Ridgecrest, North Carolina.

A native of McDonough, he studied at Mercer University and Emory University, and was associated with Jersey Medical Center and Memorial Hospital in New York City before beginning his 40-year practice in Griffin.

He was an active member of the First Baptist Church of Griffin and of the Rotary Club, serving both in many different capacities.

Survivors include his wife, a son and a daughter.

John Charles O'Neill, III

John "Jack" Charles O'Neill, III, M.D., 30, died July 18, at St. Joseph's Hospital in Savannah.

Dr. O'Neill was born in Claxton and reared in Savannah. He was a standout quarterback for Jenkins High School, Savannah, and Georgia Tech. He graduated from the Medical College of Georgia, where he was a member of the Theta Kappa Psi Medical Fraternity and served his internship at Grady Memorial Hospital in Atlanta. He completed his surgical residency at Baptist Memorial Hospital in Memphis, Tennessee, and his residency in internal medicine at Memorial Medical Center.

Dr. O'Neill was a member of the Isle of Hope United Methodist Church, the Georgia Medical Society, the Medical Association of Georgia, and the American Medical Association. He was an emergency room physician at Candler General Hospital and on staff at both St. Joseph's and Memorial hospitals.

Survivors include his wife, a son, one daughter, his mother, his step-mother, step-father, maternal grandparents, paternal grandmother, four sisters, and three brothers.



Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from May 16 through June, 1980.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Rodolfo Ruben Agraz, Marietta
Henry Alperin, Augusta
John Carl Ammons, Decatur
Daniel Jacob Appelrouth, Atlanta
Hilmi Oguz Arseven, Lithia Springs
Jose Roberto Bejarano, Milledgeville
Pedro Luis Benitez, Savannah
Robert Lowry Berry, Villa Rica
Judson Gregory Black, Atlanta
Rodrigo Bonfante, Milledgeville
Betty Ann Brooks, Decatur
Carroll Daniel Cabaniss, Columbus
Richard D. Carr, Decatur
Robert Harold Carter, Savannah
Robert Eugene Clayton, Columbus
Thomas A. Cochran, Columbus
John Marvin Crymes, Savannah
Bernard Franklin Davies, Atlanta
Jose M. De La Torre, Milledgeville
Javad Dehghanian, Snellville
James F. Densler, Atlanta
James Louis Doerr, La Grange
Richard M. Draffin, Savannah
Michaela Dynin, Savannah
Henry T. Edmondson, Augusta
Marcelo A. Estrada, Warm Springs
Ira A. Ferguson, Atlanta
Sumner Leon Fishbein, Augusta
John T. Galambos, Atlanta
Shanadi L. R. Ganesh, Dublin
Pilar Goicoechea, Hardwick
Lourdes N. Gordon, Stone Mountain
Wallace Eugene Griner, Columbus
Edward Evans Hahn, Savannah
Wa'El David Hammad, Atlanta
John Barnett Hardman, Atlanta
William V. Harrison, Folkston
Louis Abraham Hazouri, Columbus
Grady F. Herring, Fort Benning
Julius N. Hill, Atlanta
Wm. C. Humphries, St Simons Island
Richard A. Hurd, Atlanta
Louis Jerry Jacobs, Milledgeville
Garland F. Jones, Augusta
Frank F. Ledford, Fort Benning
Alva Hamblin Letton, Atlanta
Padmanabha Maramreddy, Waycross
Barry Saul Mayer, Thomasville
William Edgar Mayher, Albany
Marilynne Byrd McKay, Decatur
Kyriakos M. Michaelides, Austell
Chester O. Miller, Atlanta
Frank Richard Miller, Thomasville
Victor A. Moore, Augusta
Wayne S. Morris, Athens
Edward Oliver Nix, Decatur
Donald H. Nixon, Augusta
John B. O'Neal, Elberton
Zbigniew L. Olkowski, Atlanta
Ih Koo Park, Fort Oglethorpe
Geraldine G. Pilcher, Augusta
John L. Powell, Atlanta
Arturo G. Rodriguez, Milledgeville
Clarence M. Rogers, Stone Mountain
Joseph W. Rubin, Augusta
Robert C. Schlant, Atlanta
Charles B. Shiver, Augusta
Alan John Sievert, Riverdale
Bruce A. Smith, Albany
Hilton Eugene Smith, Columbus
Renato Chaves Souza, Fairburn
Satyanarayana K. Tikare, Augusta
Corbett Harold Turner, Atlanta
John A. Ward, Decatur
Richard S. Ward, Atlanta
Paul Daniel Webster, Augusta
Hugo Jacob Zee, Columbus

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.

© WEIGHT WATCHERS INTERNATIONAL, 1977

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Tenuate® ℞
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to.
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

Merrell

9-4672 (Y957A)

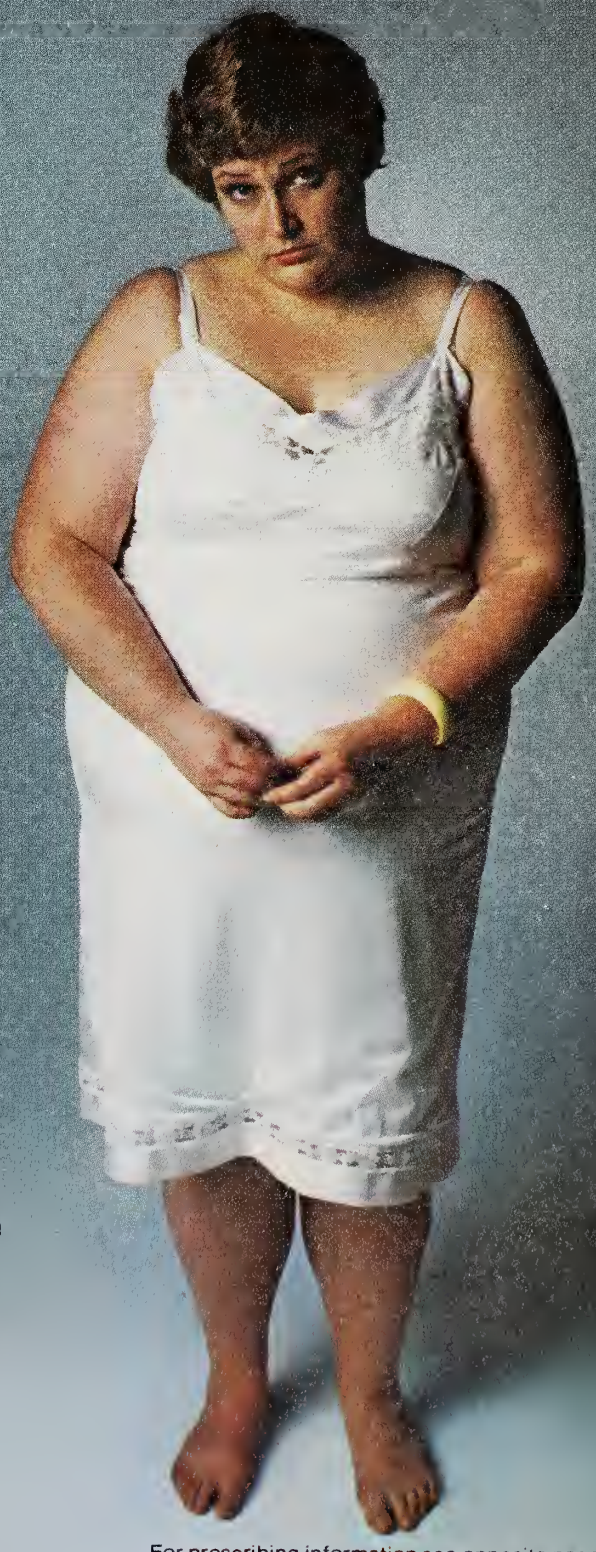
Overweight may not always be simple... complications can develop.*

Complicated or not...

Tenuate® Dospan® (IV)

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy; benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

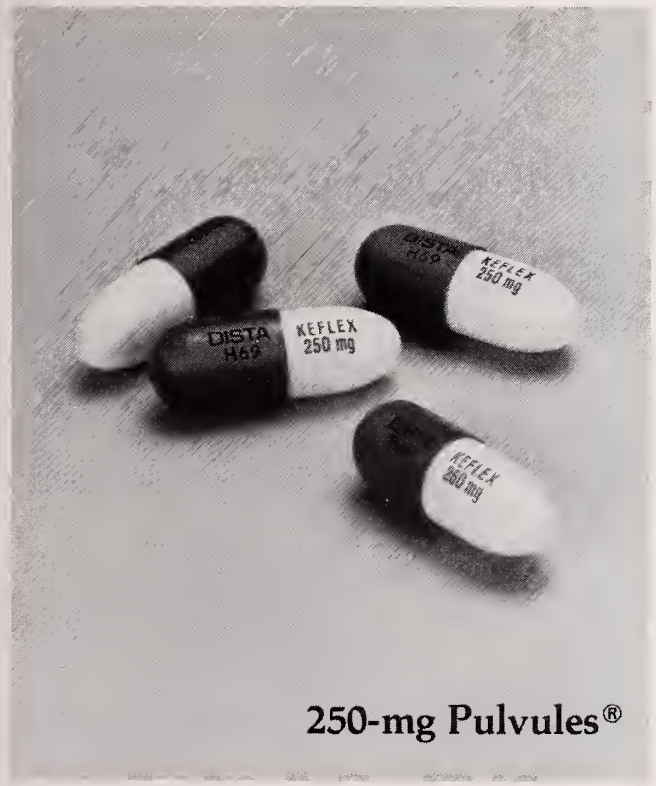
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision; urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc.
Manati, Puerto Rico 00701

easy to take



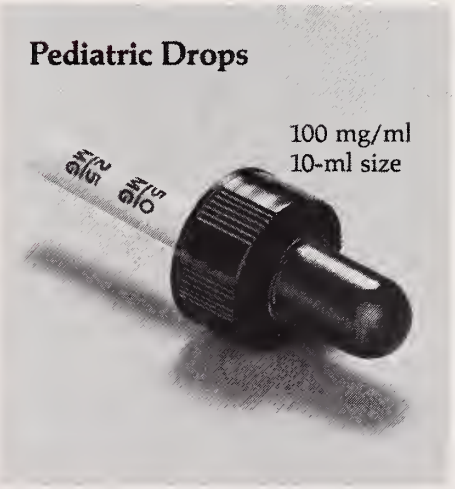
250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes



Pediatric Drops

100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS
(mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

© Janssen Pharmaceutica Inc 1980 JPI-023



Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

Serving the General Insurance needs of
the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

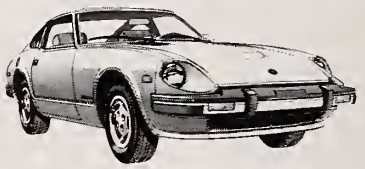
THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Datsun 280-ZX 2-Seater Deluxe

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

TEGA-TUSSIN - CIII

FOR MAXIMUM RESULTS IN CONTROL OF COUGHS DUE TO THE COMMON COLD

EXCELLENT TASTE

Each 30cc contains:

Dihydrocodeinone Bitartrate 25 mg.

WARNING: May be habit forming

Chlorpheniramine Maleate 10 mg.
Phenylephrine Hydrochloride 30 mg.
Potassium Guaiacolsulfonate 500 mg.

TEGA-TUSSIN: Provides chlorpheniramine maleate, the anti-histamine with virtually no side effects.

TEGA-TUSSIN: Provides potassium gulacol-sulfonate, an excellent expectorant.

TEGA-TUSSIN: Provides phenylephrine HCL, an effective respiratory mucosal, pulmonary decongestant, mild bronchodilator and vaso-pressor.

DOSAGE: Adults - One teaspoonfull every 3 to 4 hours. Children over 6 years - ½ Adult dose. Not recommended for children under 6 without very close supervision by physician.

AVAILABLE ON RX ONLY

MORE DETAILED INFORMATION AVAILABLE ON REQUEST

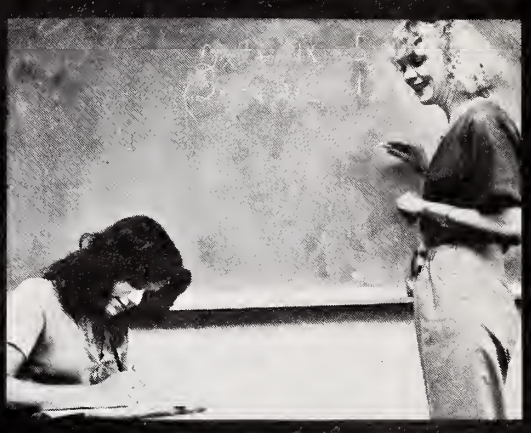
WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTH-EAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PRODUCTS ARE DESIGNED WITH THE FAMILY PHYSICIAN IN MIND

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205






Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited; separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567

Index to Advertising

Vol. 69 September 1980 No. 9

American Medical Association 751
Ballard, Walter, Optical Company 792
Boots Pharmaceutical 771-774
Brawner Psychiatric Institute 748
Burroughs Wellcome Company 782, 784
Classifieds 801
Decatur Hearing Aid Service 797
Dickey-Mangham Company 782
Electric Research Corporation 734
Fulton Federal Savings and Loan Association 744
Gatsby, Jr., and Company 740
Georgia Society of CPAs 798
Global Imports 767
The Great Cherokee Trading Company 798
Hickman-Datsun 798
Insurance Corporation of America 737
Janssen Pharmaceuticals 797-798
Lilly, Eli, and Company 795
MAG Scientific Assembly 768
Merck, Sharp, & Dohme 752-754
Merrell-National, Inc. 782-783, 792-793
Metro Ambulance 775
Newtron Sales 802
Nutrition Services Center 763
Ortega Pharmaceutical Company, Inc. 798
Peachford Hospital 738-739
Peachtree and Parkwood Mental Health Center and Hospitals 764
Potter-Holden and Company 797
Psychiatric Institute of Atlanta 781
Ridgeview Institute 799
Roche Laboratories 732-733, 803-804
United Way 763
Valley Psychiatric Hospital 801
Weight Watchers of Greater Atlanta 792
Willingway Hospital 790
Wyeth Laboratories 741-742

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$10.00 for the first 25 words; $.25 per word for each additional word. **Non-members**—$20.00 for the first 25 words; $.25 per word for each additional word. *Charges are payable in advance*. Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535. INWATS in Georgia (800) 282-0224.

SITUATION WANTED

Psychiatrist desires association in a group or clinic or purchase of an active practice. Available by August-September 1980. Please write to Box 7-A, c/o the *Journal*.

PHYSICIANS WANTED

Solo OB-GYN practitioner needs associate in his practice located in Decatur. Please respond to Box 8-A, c/o the *Journal,* 938 Peachtree St., NE, Atlanta 30309.

Qualified Gynecologist-Bariatrician needed to take over active practice in midtown Atlanta. Send CV to Box 9-A, c/o the *Journal,* 938 Peachtree St., NE, Atlanta, GA 30309.

Director of Anesthesiology — Position located in lovely community of eastern North Carolina. Choice of establishing private solo practice with stipend for directorship or taking salary position as employee in well-equipped and computerized hospital. Back-up coverage provided. Good benefits. Call Durham Medical Search at (716) 852-5911. 505-N Statler Office Bldg., Buffalo, NY 14202.

Available locum tenens for all or part of October-December for general practice office coverage. John C. McCamy, M.D., Diplomat AAFP, 578 Campbell Hill, Marietta, GA 30060. (404) 428-5721.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call (404) 634-1234.

TO RICH DOCTOR OR RICH ARABS — 192½ acres, level, wooded, land — 2 miles WSW of the courthouse at Butler, Taylor County, Georgia. Completely reforested in slash pines. Town of Butler growing westward toward this property. Seller retains ½ interest in all mineral rights. This is a steal at $1000.00 per acre. Call 912-929-1485 or write Timothy Swan, 107 Imperial Circle, Warner Robins, Georgia 31093.

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

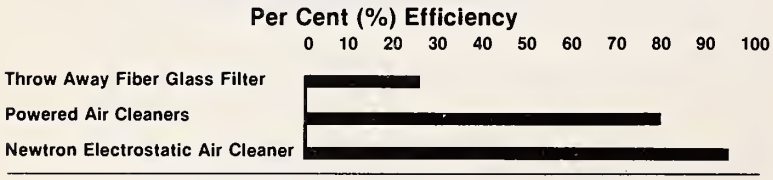
Administrator
Dennis P. Dobard

Doctor, your patients will be asking about the Newtron® Electrostatic Air Cleaner.



And with good reason. The Newtron® electrostatic air cleaner is a revolutionary new device that allows allergy patients to breathe clean air in their homes and offices — at a much lower cost than has ever been possible before.

In fact, the Newtron® is the only reasonable answer to the problems caused by pollen, dust, smoke, and other air pollutants. It requires no electricity, never needs to be replaced, requires no maintenance other than a monthly rinsing with tap water, and comes in standard filter sizes to simply replace the existing throw-away filter in heating and air conditioning systems. Even more importantly, it far out-performs all other cleaners, including electrically powered models costing more than three times as much.



In the past, high costs and complicated installation have put truly clean air out of the reach of most allergy patients. Now that the Newtron® is available — and has been proven effective in hospitals, businesses, private homes, and apartments — your patients will be asking for your approval or opinion.

Please allow us to send you a complete information package on the Newtron®. No salesman will call, either in person or by telephone (unless you request it). The price of the Newtron® varies from $195 to $205, according to size. (Master Charge® and VISA® are accepted.) Professional discounts on Newtron® electrostatic air cleaners are available to physicians who wish to purchase one unit for their personal use.

Newtron®

The ultimate air cleaner.

Clip and mail this coupon to

Newtron Sales
202 Nottingham Ln.
Slidell, La. 70458

Please send complete information on the Newtron® electrostatic air cleaner.

Dr. _____

Address _____

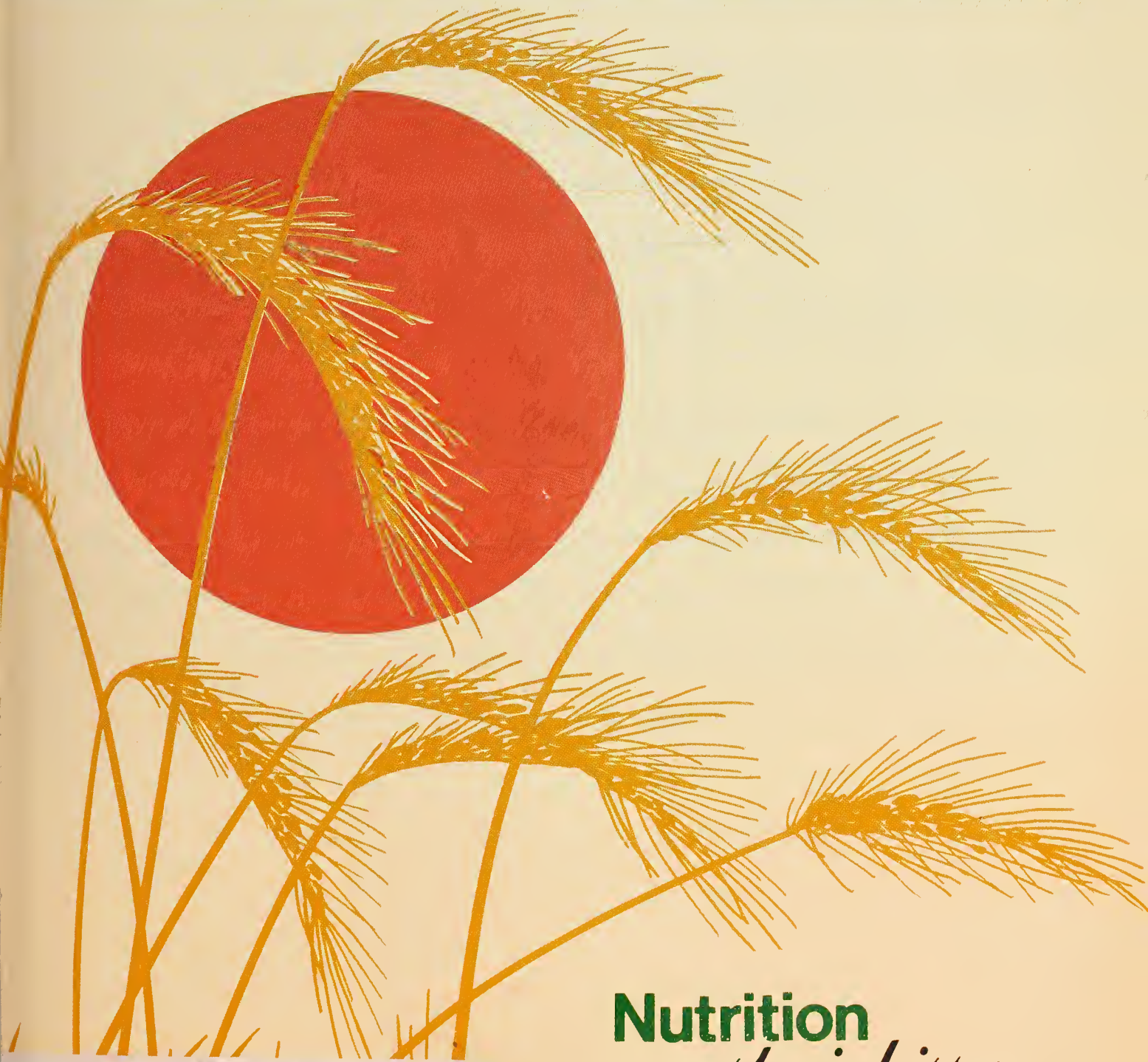
City _____ State: _____

Zip: _____

Specialty: _____

Newtron® is a registered trademark of Newtron Products Co., Cincinnati, Ohio
The generic name is electrostatic air cleaner

JOURNAL
of the medical association of
georgia
ISSN-0025-7028 OCTOBER / 1980



Nutrition
... a special issue

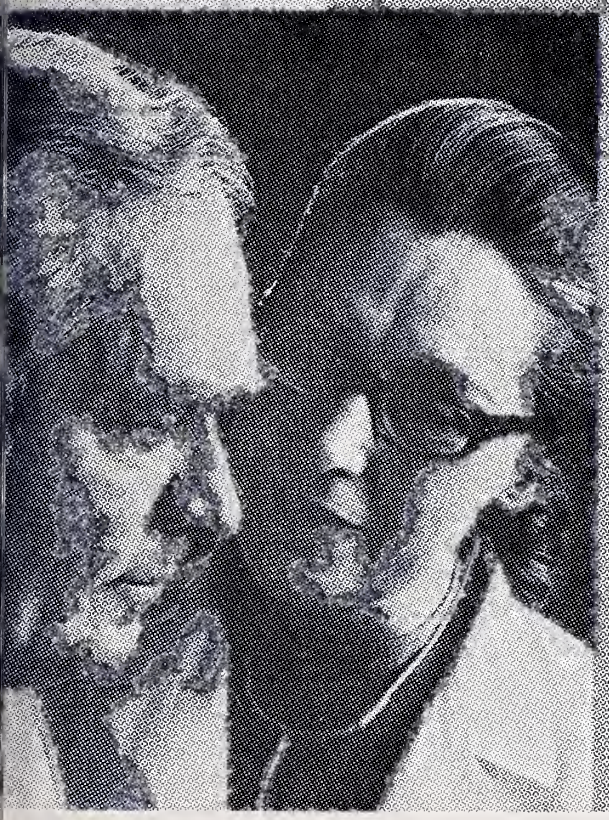
LIBRARY
U.C. SAN FRANCISCO
NOV 3 1980



proven antianxiet

Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). **And today this promise continues to be fulfilled in a wide variety of patients you see every day.**

ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® ℞
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

American Medical Association
PHYSICIANS' PLACEMENT SERVICE

LOOKING FOR A PLACE TO PRACTICE?

If you'r seeking a practice opportunity, the AMA's Physicians' Placement Service is the best source of information on positions available. Because the listings cross geographic and specialty lines, the AMA's Physicians' Placement Service is the largest and most comprehensive in the field.

Published quarterly, the **Opportunity Placement Register** lists thousands of openings indexed by specialty, type of practice, date of availability, financial arrangements, location and size of community, etc.

The companion **Physician Placement Register** contains your coded resume and is sent to communities, clinics, hospitals, corporations, and others seeking the services of a physician providing you with important additional exposure.

For further information and a copy of the current **Opportunity Placement Register,** write:

AMA Physicians' Placement Service
535 N. Dearborn Street, SJ
Chicago, Illinois 60610

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



Only $225 a month

DATSUN 280-ZX

We're Specialists in
LUXURY, PERFORMANCE, ECONOMY
AND
We have the South's best service for the whole Datsun Line!

JOURNAL
of the medical association of georgia

contents

VOLUME 69, NUMBER 10

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/ EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director
Joyce Butler, R.N., Assistant Executive Director
J. Tom Sawyer, Assistant Executive Director
Kenneth M. Williams, Director of Public and Professional Relations
Stephen Davis, Director of Education
Bert Franco, M.A., Assistant Director of Medical Practice
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SPECIAL ISSUE: NUTRITION

815 Nutritional Support of the Trauma Patient
Jed Horowitz, M.D.
Janet Smith, M.M.Sc., R.D.
Steven Heymsfield, M.D.
827 Salt and Hypertension
Louis Tobian, M.D.
837 Educating the Student, Informing the Physician on Nutrition
Elaine B. Feldman, M.D.
Maurice Levy, Ed.D.
Robert H. Curry, M.D.
841 Potential Barriers to Good Nutrition
Donna R. Watson, M.S., R.D.
Sandra Mossbrook, M.D.
Martha Jane Johnson, M.S., R.N.
845 Real and Perceived Issues on Food Safety — A Nutrition Perspective
Allan L. Forbes, M.D.

OTHER ARTICLE

855 Retirement Plans Available to Medical Practices
Larry L. Ott, C.P.A.

EDITORIAL

849 Nutrition — An Overview of This Special Issue
Judson G. Black, M.D.

FEATURES

859 Legal Page/Investment Via Limited Partnership: Limited Deductions, Limited Liability, Limited Control
William J. Armstrong
863 Heart Page/Therapy of Hypertrophic Cardiomyopathy — New Directions
Mario I. Canedo, M.D., F.A.C.C.

THE ASSOCIATION

865 President's Letter/CME — A Vital Necessity
H. Hilt Hammett, Jr., M.D.
867 New Members
867 Personals
868 Societies
868 Deaths
869 Annual Negotiating Session Between the MAG and St. Paul. The Continuing Saga of the Rising Rates
Charles R. Underwood, M.D.
873 Physician's Recognition Award

INCIDENTAL INTELLIGENCE

810 AMA Auxiliary Holds Annual Conference
810 The Nursing Shortage — Is There A Cure?
813 Medical Meeting Calendar

COVER

Grain — one of the ultimate sources of much of human nutrition. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

AMA Auxiliary Holds Annual Convention

Twelve delegates and four alternate delegates represented the Auxiliary to the MAG at the AMAA Annual Convention in Chicago, July 21-23, 1980.

AMAA President, Mrs. Ben F. Johnson, Jr., presented the AMA with a check for $1.6 million that the Auxiliary had raised in the past year for the AMA-Education and Research Foundation. The total amount contributed to date is over $32 million. She reported an increase of 689 in national membership for the 1979-80 year, and that the Shape-up for Life program had been a success in its first year. Restating her theme for the year, "Purpose, Courage, and Optimism," Mrs. Johnson said that the Auxiliary's accomplishments have kept the organization in tune with the changing times as it moves into the 1980's and that our potential as a group is unlimited.

For the first time, Reference Committee hearings were held. These provided an orderly forum for testifying about proposed amendments to the Bylaws, recommendations from the Board of Directors, and proposed resolutions about various health issues.

The current state presidents were introduced to the House of Delegates, and the Georgia delegation felt a sense of pride when Mrs. Milton B. Satcher was presented. Georgia's immediate past-president, Mrs. Michel A. Glucksman, gave a summary of her year as president of A-MAG.

Letitia Baldridge, former social secretary to the Ambassador and Mrs. David Bruce in Paris, assistant to Ambassador Clare Booth Luce in Rome, and social secretary to the White House in the 1960s was one of the featured speakers. She gave a capsule of diplomatic faux pas she had committed in her career. Other speakers included Jessica Savitch, an NBC news commentator, and C. Carson Conrad, Executive Director of the President's Council on Physical Fitness and Sports.



(L) Mrs. Milton B. Satcher (Ann), and Dr. and Mrs. H. Hilt Hammett, Jr., at the reception in Chicago following the inauguration of the new President of the American Medical Association, July 23, 1980.

On the final day of the convention, Mrs. John F. Vaugh (Vancouver, Washington) was installed as President; Mrs. Harry S. Dvorsky (San Leandro, California) as President-elect; and Mrs John G. Bates (our own Glenda from Cuthbert, Georgia) as First Vice-President.

The Credentials and Registration Report showed 41 national delegates, 309 state delegates, 75 alternate delegates, 86 members, and 75 guests, for a total registration of 586.

(Reported by Mrs. Perry M. White, President-elect, Auxiliary to the MAG)

The Nursing Shortage — Is There a Cure?

We now have a bonafide nursing shortage. This fact has taken a while to register on most of us. I first became aware something was up when the Intermediate Intensive Care Unit closed several months ago. Recently there are rumblings that the Coronary Care Unit is becoming difficult to keep staffed adequately. The problem is national in scope.

Why is this happening? I can suggest three major reasons.

1. **Pay** — Simply put, for a qualified, reliable, and diligent person, more money can be had in other jobs than in nursing. With a nursing background, one can enter a number of medically related careers, which often pay better than staff nursing jobs. Furthermore, women are finding that social changes have opened up more jobs to women than ever before.
2. **Hours** — Nurses work 24 hours a day, 7 days a week, 52 weeks a year. The odds are that the average nurse works far more nights, weekends, and holidays than does even the proverbial hard-working doctor. It is a known fact that many nurses choose not to work because coming back to work traditionally involves taking the worst shifts and giving up traditional days off.
3. **The job itself** — Nursing, like medicine, has changed in the past 20 years. ICUs and CCUs did not exist then as they do now. Some claim that the educational process in nursing schools has not kept up with these changes. Nursing has become more technical, mathematical, and scientific. Today's nurse is expected to read EKG's and treat arrythmias, defibrillate, and perform CPR. She is expected to trouble shoot ventilators and handle the

intracardiac monitors. She does less caring and comforting, more diagnosing and treating. In effect, the ICU nurse is an experienced house officer.

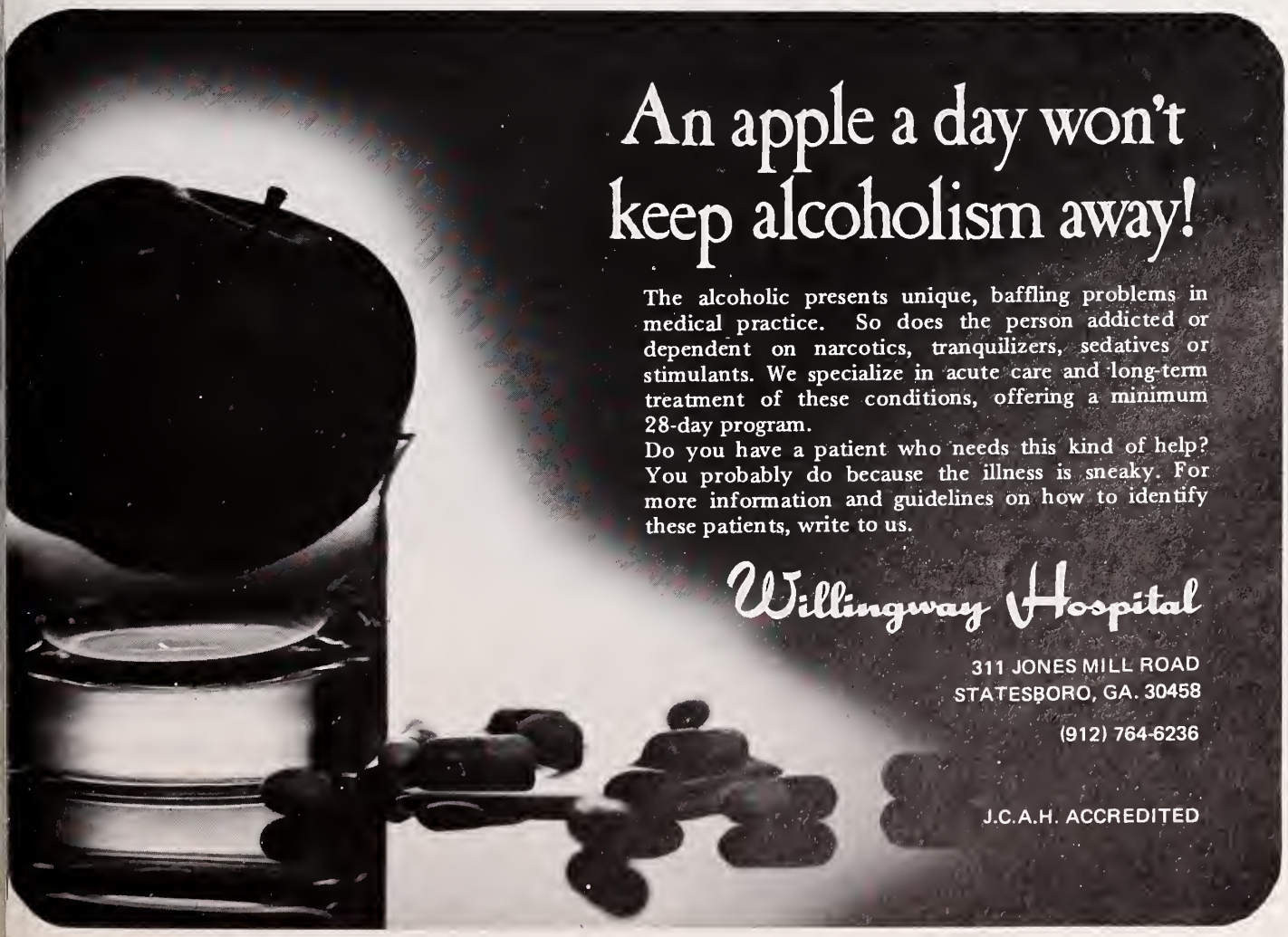
Sometimes physicians don't like to admit this transformation. It may be threatening. Doctors have a tendency to depend on nurses to make life and death decisions but not to give them the credit where it is due. This leads, all too often, to anger and frustration. Little wonder that some of our best nurses have opted out of ICU work and taken less demanding and stressful jobs.

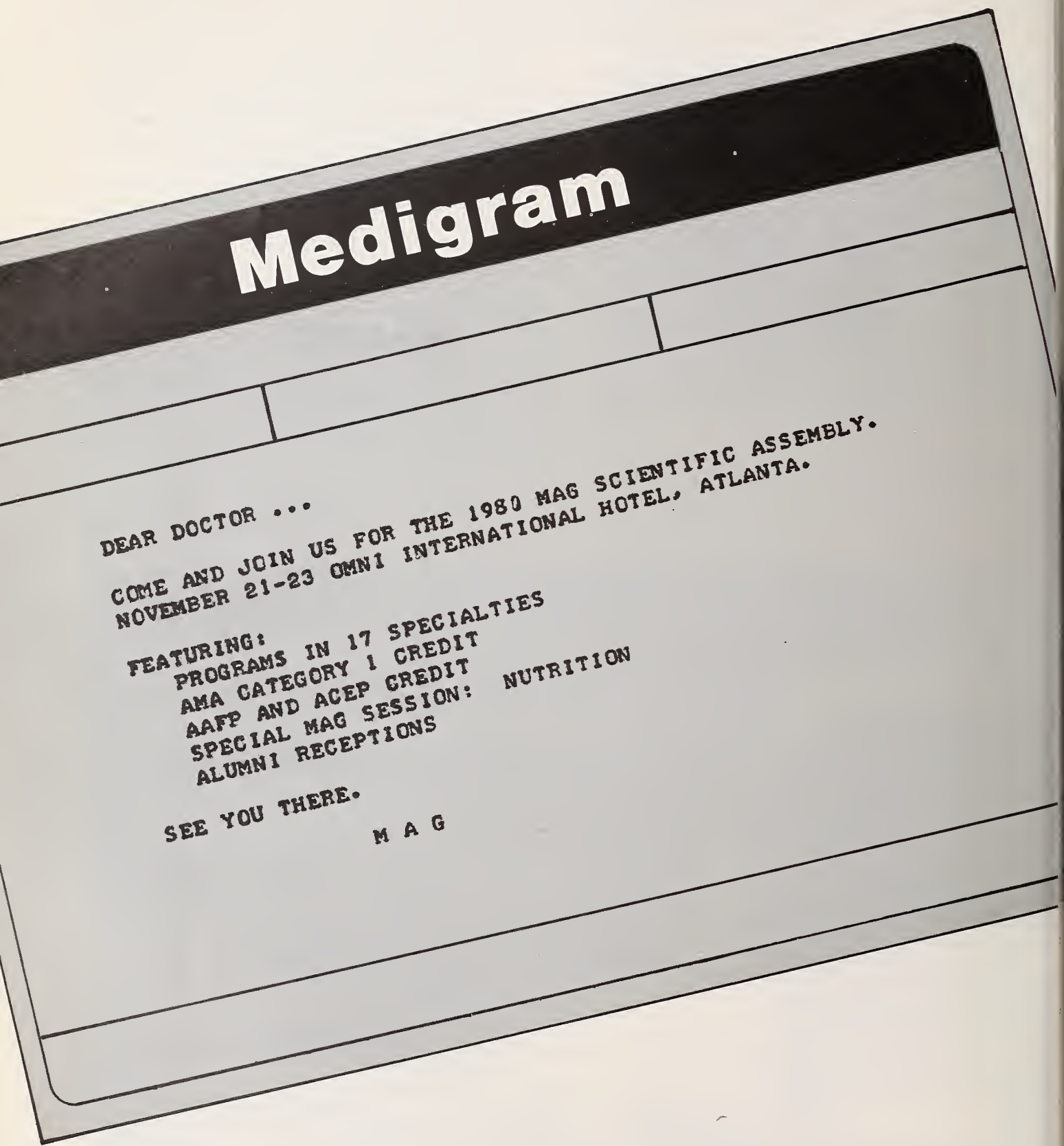
What are the solutions? At a recent ICU meeting it was "decided" that more education was the answer to the nursing shortage. More lectures, more courses, more in-services, etc. Personally, I think this approach, while laudable for other reasons, has about as much chance for solving the nursing crisis as sex education had several years ago when it was promoted as a solution to unwanted pregnancies. Education could backfire. When you provide education, you simply increase responsibility. When you teach the right way to do something, the student naturally feels a certain obligation to see to it that the correct practice is observed. When it isn't, frustration sets in. Too often the nurse feels she has taken on the responsibility but is not given the authority to follow through.

I think physicians can have an impact on the nursing crisis if we better recognize that nursing has matured. So should we. Here are some suggestions.

1. Be civil. Learn to say hello and thank you. Our wives have been insisting on it recently. Nurses will shortly.
2. If something goes wrong and you feel the need to have a temper tantrum, don't. A nurse is not a garbage can for your emotions. Go home and pull crabgrass out of the lawn instead.
3. If you sense that the nurse knows more about the patient's problem or management than you do, don't get mad. Get a consult.
4. Read the nurse's notes. Nurses are less biased toward improvement than physicians.
5. No matter how much it pains you, always thank a nurse who calls you on the phone. If you don't, they will stop calling.
6. If a nurse makes a suggestion, try to go along with it if it is at all reasonable. Nurses will take better care of your patients if they know they are contributing.

William W. Reichert, M.D. (Reprinted from the DeKalb Medical Society Newsletter)




Medigram
DEAR DOCTOR ...
COME AND JOIN US FOR THE 1980 MAG SCIENTIFIC ASSEMBLY.
NOVEMBER 21-23 OMNI INTERNATIONAL HOTEL, ATLANTA.
FEATURING:
PROGRAMS IN 17 SPECIALTIES
AMA CATEGORY 1 CREDIT
AAFP AND ACEP CREDIT
SPECIAL MAG SESSION: NUTRITION
ALUMNI RECEPTIONS
SEE YOU THERE.
M A G

MEDICAL MEETING CALENDAR

OCTOBER

19-24—*Atlanta;* **66TH ANNUAL CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS;** Category 1 credit; Contact: Dianne Currie O'Rourke, Mgr. of Public Information, American College of Surgeons, 55 E. Erie St., Chicago, IL 60611.

24-26—*Atlanta;* **CLINICAL MANAGEMENT OF CORONARY DISEASE AND EXERCISE TESTING;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800-525-8646.

25-30—*Washington, DC;* **91ST ANNUAL MEETING OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES;** Contact: AAMC Annual Meeting, One Dupont Circle, NW, Washington, DC 20036.

25-30—*Detroit, MI;* **AMERICAN ACADEMY OF PEDIATRICS 50TH ANNIVERSARY MEETING;** Category 1 credit; Contact: Joanna Hague, P.O. Box 1034, 1801 Hinman Ave., Evanston, IL 60204. PH: 312/869-4255.

26-30—*Boston, MA;* **46TH ANNUAL SCIENTIFIC ASSEMBLY OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS;** Category 1 credit; Contact: Mary Ellen Pictor, Press Relations Coordinator, American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

31-Nov. 2—*Callaway Gardens;* **PRE-PRACTICE SEMINAR AND PHYSICIAN RECRUITMENT CONFERENCE;** Contact: Dottie Dance, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535.

NOVEMBER

2-5—*Helen;* **PSYCHIATRIC INSTITUTE ON GROUP BEHAVIOR AND GROUP LEADERSHIP;** Contact: Emory University Sch. of Med., 69 Butler St., SE, Atlanta 30303.

2-5—*Washington, DC;* **COMPUTER APPLICATIONS IN MEDICAL CARE;** Category 1 credit; Contact: Janice Eldridge, Office of CME, George Washington Univ., 2300 K Street, NW, Washington, DC 20037. PH: 202/676-4285.

5-7—*Houston, TX;* **25TH ANNUAL CLINICAL CONFERENCE ON GASTROINTESTINAL CANCER;** Contact: Steve Stuyck, M.D. Anderson Hospital and Tumor Institute, Texas Med. Ctr., 6723 Bertner Ave., Houston, TX 77030. PH: 713/792-3030.

6-8—*Atlanta;* **32ND ANNUAL GAFP SCIENTIFIC MEETING;** Category 1 credit; Contact: Camille Day, Exec. Dir., GAFP, 11 Corporate Sq., Ste. 205, Atlanta 30309. PH: 404/321-7445.

14—*Birmingham, AL;* **SELECTED TOPICS IN HEPATOLOGY AND PEPTIC ULCER DISEASE;** Category 1 credit; Contact: Medical Staff Affairs Dept., Brookwood Med. Ctr., Birmingham, AL. PH: 205/877-1944.

14-16—*Sea Island;* **PRIMARY CARE OF HAND INJURIES;** Contact: American Society for Surgery of the Hand, 2600 South Parker Rd., Ste. 132, Aurora, CO 80014. PH: 303/755-4588.

15-16—*Albany;* **1980 GEORGIA ASSOCIATION OF EMERGENCY MEDICAL SERVICES CONFERENCE;** Contact: C. B. Gillespie, MD, 810 14th Ave., Albany 31701. PH: 912/435-1458.

16-19—*San Antonio, TX;* **SOUTHERN MEDICAL ASSOCIATION'S 74TH ANNUAL SCIENTIFIC ASSEMBLY;** Contact: SMA, 2601 Highland Ave., Birmingham, AL 35205. PH: 205/323-4400.

16-21—*Dallas, TX;* **RADIOLOGICAL SOCIETY OF NORTH AMERICA 66TH SCIENTIFIC ASSEMBLY AND ANNUAL MEETING;** Category 1 credit; Contact: RSNA, 1415 West 22nd St., Ste. 1150, Oak Brook, IL 60521. PH: 312/920-2680.

21-23—*Atlanta;* **1980 MAG SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 1-800-282-0224 (toll-free in Georgia).

DECEMBER

3-7—*Atlanta;* **57TH SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE;** Contact: Mary Galos, Peachford Hospital, 2151 Peachford Rd., Atlanta 30338. PH: 404/455-3200, ext. 550.

5-7—*Atlanta;* **CARDIAC ISCHEMIA AND ARRHYTHMIAS;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800-525-8646.

12—*Atlanta;* **6TH ANNUAL INFECTIOUS DISEASES SEMINAR—1980;** Category 1 credit; Contact: Dept. of Graduate and CME, GA. Baptist Med. Ctr., 300 Boulevard, NE, Atlanta 30312. PH: 404/659-4211, ext. 2346.

12-13—*Jackson, MS;* **THIRD ANNUAL COURSE ON STRABISMUS;** Contact: Dr. Raul E. Valenzuela, Univ. of Mississippi Med. Ctr., 2500 N. State St., Jackson, MS 39216.

22-31—*Aspen, CO;* **MEDICAL LEGAL SEMINAR;** Contact: B. J. Cahn, M.D., 3576 Chamblee-Tucker Rd., Atlanta 30341. PH: 404/934-3326.

JANUARY 1981

24-27—*Atlanta;* **AMA WINTER SCIENTIFIC MEETING;** Category 1 credit; Contact: Council on Continuing Physician Ed., AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

24-31—*Snowmass, CO;* **5TH ANNUAL CONFERENCE ON PAIN: FACIAL and NECK PAIN;** Category 1 credit; Contact: Ronald G. Havican, Ctr. for Rehab. Med., Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5507.

26-31—*Puerto Rico;* **PEDIATRICS IN REVIEW—1981;** Contact: Judson Hawk, Jr., MD, Scottish Rite Hospital for Crippled Children, 1001 Johnson Ferry Rd., Atlanta 30342.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



"Every Age has its Pleasures, its style of Wit, and its own Ways."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

Pavabid® and Pavabid® HP

(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

JOURNAL
of the medical association of
georgia

Nutritional Support of the Trauma Patient

JED HOROWITZ, M.D., JANET SMITH, M.M.Sc., R.D., and
STEVEN B. HEYMSFIELD, M.D., *Atlanta**

TRAUMATIC INJURY in the United States results in more than 100,000 deaths and 50 million non-fatal injuries annually. It remains the leading cause of death in individuals under 30 years of age, and overall it is the fourth leading cause of death in all age groups. Accident victims occupy 12% of all hospital beds.

The care of the acutely injured patient has undergone major advances in recent years. Increased survival during the early post-injury period can be attributed to a number of factors, including improved transport facilities, well-trained emergency medical teams, and advances in medical and surgical therapeutics. In the late post-injury period, decreased morbidity and mortality relies upon the early treatment of sepsis, respiratory failure, and wound dehisence.

Research at the basic science level has improved our understanding of the metabolic response to severe injury. Subsequently, the importance of vigorous nutritional support for these intensely catabolic patients has become apparent. Until recently, the methods and products available for nutritional management were limited in scope. New developments in enteral and parenteral hyperalimentation have facilitated the physician's ability to meet each patient's individual requirements. These advances have led to a reduced rate of complications and deaths.

* Ms. Smith and Drs. Horowitz and Heymsfield are from the Department of Surgery and Medicine, Emory University School of Medicine. Address reprint requests to Dr. Heymsfield at the Department of Surgery and Medicine, Emory University School of Medicine, Atlanta, GA 30322.

Physiologic Response to Trauma

The person suffering from severe injury, sepsis, major burn, or extensive surgery experiences a profound series of metabolic and endocrine events.[1] Fever and chills, increased respiratory effort, new tissue synthesis, and stress-related changes in catecholamines contribute to hypermetabolism in these patients.[2] In the severely burned patient, the energy loss due to water evaporation (0.5 Kcal/cc H_2O) can, in itself, range from 2000 to 4000 Kcal/day.[3]

The first several weeks following severe injury are termed the *acute catabolic phase*,[4] and as might be expected, result first in resorption of liver glycogen stores and then depletion of fat and protoplasm to supply free fatty acids and amino acids for metabolism. Whereas prolonged starvation results in protein-sparing adaptations, the individual stressed by injury experiences accelerated catabolism which proceeds in a characteristic sequence to supply glucose for the continuing requirement of brain and other glycolytic tissues.[5] Intestinal and liver enzymes which metabolize orally ingested food are degraded first, followed by resorption of kidney, heart, and skeletal muscle proteins. The patient shows a negative balance of potassium, sulfur, phosphorous, and nitrogen.[6] This is associated with weight loss, a decline in muscle mass, loss of immunocompetence, and retarded wound healing.[7]

If the patient survives the acute catabolic phase, a *turning point* develops over several days, characterized by a decline in energy and nitrogen losses and a return of gastrointestinal motility. Appetite improves, and when nutrient intake exceeds utilization,

the patient enters the *anabolic phase*. Depleted body stores are then restored over weeks or months.[4]

Causes of Undernutrition

Adequate nutritional management is influenced by the factors contributing to undernutrition. Diminished intake may be secondary to anorexia, mechanical causes, or maintenance of crystalloid intravenous fluids. To assess nutrient intake, an adequate diet record should be maintained daily by the dietician.

Nutrients may be lost through the kidneys, skin (severe burn), or gastrointestinal tract (nasoenteric suctioning, fistulae, diarrhea, and malabsorption). The patient's weight and fluid balance should be recorded daily; aliquots of urine and gastrointestinal fluids are analyzed for electrolyte and protein content; stool may be tested for fat and nitrogen. Early renal dialysis, surgical coverage of large burns, and operative repair of open wounds and fistulaes will decrease losses through these routes.

Controlling the patient's environment may diminish the degree of hypermetabolism. Narcotics and tranquilizers diminish pain and anxiety, while excessive cold or fever can be modified by adjusting the ambient temperature of the room.

Long-standing chronic illness is an additional parameter affecting the nutritional status of the trauma victim. Individuals with diabetes, liver, renal, and/or cardiovascular disease will often be malnourished and require specialized dietary regimens. The care of these complex cases clearly presents a challenge to the nutritional support team.

Assessing Undernutrition and Nutrient Requirements

First, it is necessary to establish a nutritional status baseline. The pre-morbid status and the severity of injury determine the type of therapy required. In addition, the baseline provides a starting point to gauge the effect of the nutritional therapy.

Body weight should be recorded as the absolute value and as a percent of ideal. Triceps skinfold thickness and mid arm fat area provide an index of adipose stores.[8, 9] Muscle mass, constituting 30% of all total body protein, can be approximated by the mid arm muscle circumference and mid arm muscle area. An additional method is the 24-hour urinary creatinine excretion, normalized for height (creatinine/height index (CHI)).[10, 11] Visceral protein stores may be estimated by serum levels of albumin and transferrin.[8, 12]

The measurement of hypermetabolism is most accurately performed by direct and indirect calorimetry.[13] A more practical method, however, utilizes simplified energy expenditure equations which provide a rough estimate of the daily caloric needs (Table 1).

Hyperalimentation

When the injured patient cannot be maintained by spontaneous oral feedings, intervention with "forced" feedings is required. Procrastination in instituting an adequate hyperalimentation program often results in the serious complications previously mentioned. Broadly viewed, the clinician has three options with respect to the nutritional management of this type of patient. The first option is to infuse "hypocaloric protein-sparing" peripheral intravenous solutions, which can retard the rapid rate of protoplasm breakdown characteristic of total starvation.[14, 15] The second option is to maintain lean body mass by administrating 0.7 to 1.0 times the recommended daily allowance (RDA) of each nutrient by enteral or parenteral techniques. The third option is to replace lean tissue proteins in the cachectic patient by means of repletional doses (2-3 times the RDA) of hyperalimentation. The majority of severely injured patients are in this latter category.

The route of nutritional support is determined by the patient's symptoms as well as by mechanical and economic considerations. The enteral route should be considered first because it is physiologic, simple, economical, and well-tolerated in most patients.[16] Factors which may contraindicate its use include intractable vomiting, intestinal obstruction, and upper gastrointestinal bleeding. Difficulties of diarrhea or malabsorption can often be circumvented by constant enteral infusion of an elemental feeding mixture. Reducing the flow rate will sometimes improve persistent symptoms of nausea, vomiting, or diarrhea.

If the enteral nasogastric intake must be slowed to a sub-repletion rate to achieve tolerance, then supplemental nutrition can be administered via a peripheral vein. If the combination of enteral plus peripheral alimentation remains inadequate, it should be discontinued, and central hyperalimentation initiated.

1. The Enteral Route

Three types of enteral hyperalimentation mixtures are available which differ is osmolality, digestibility, caloric density, lactose content, viscosity, fat content, taste, and expense. Polymeric mixtures contain protein, fat, and carbohydrate in high molecular weight form. They are, therefore, low in osmolality and require normal digestive, proteolytic, and lipolytic capacity. They contain approximately 1 Kcal/ml and are less expensive than the other solutions. In contrast, chemically defined products furnish protein in the form of amino acids, di and tri peptides, and oligopeptides and oligosaccharides as the carbohydrate source. These formulas are hyperosmolar, and most contain little or no triglyceride or

TABLE 1 — CALCULATION OF DAILY CALORIE REQUIREMENTS AND ADEQUACY OF ENERGY INTAKE

I. TOTAL DAILY CALORIE REQUIREMENTS

Basal Energy Expenditure (E_b) + Energy for Physical Activity (E_{pa}) + Energy of Injury of Surgery (E_{surg})

E_b (Kcal/day):

Men = 66 + (13.7 × W) + (5 × 11) − (6.8 × A)
Women = 655 + (9.6 × W) + (1.7 × 11) − (4.7 × A)
Simplified: E_b = 22 × W
W = weight, kg
H = height, cm
A = age in years

E_{pa} (Kcal/kg/hr):

Activity Level	*Men*	*Women*
Very light	1.5	1.3
Light	2.9	2.6
Moderate	4.3	4.1
Heavy	8.4	8.0

E_{surg} (Kcal/day):

Minor surgery, e.g.,	
Appendectomy	— 50-75
Cholecystectomy	— 100
Partial gastrectomy	— 150
Severe trauma	— 200-500
Trauma with sepsis	— 500-1000
Burns	— % burn × 40
Fever	— E_b × .07 × degree fever above 98.8°

II. NET DIETARY INTAKE

Calorie Intake (C_I) − Calorie Loss (C_L)

1) Enteral
2) Parenteral

1) Urine† = 100 Kcal/day
2) Stool† = 75 Kcal/day
3) SDA* = .06 × total Kcal intake/day

III. ADEQUACY OF ENERGY INTAKE

A. Maintenance II = I
B. Depletion II < I
C. Repletion II > I

Example: 50-year-old post-cholecystectomy male patient (wt = 70 kg/ ht = 175 cm) who lies in bed the majority of the day and participates in very light activity approximately 4 hours per day. Total intake equals 2000 Kcal.

I. *Calorie Requirements*

E_b	=	1560
E_{pa}	=	420
E_{surg}	=	100
		2080 Kcal

II. *Net Dietary Intake*

C_I	=	2000
C_L	=	−295
		1705 Kcal

III. *Adequacy of Energy Intake*

1705 Kcal < 2080 Kcal
II < I
Therefore, patient is in negative energy balance.

* SDA — Specific Dynamic Action.

† Values assume normal fecal and urinary losses. Values will be correspondingly higher in uncontrolled diabetes (urine) or malabsorption (stool). When on parenteral feedings, stool caloric losses will be reduced.

starch. They do not require proteolytic or lipolytic capacity, furnish approximately 1 Kcal/ml, and are moderately expensive. Chemically defined formulas are often indicated in chronic diarrheal states, especially those characterized by decreased digestion of fat and protein. They are also indicated in those cases requiring a very low residue diet, such as enterocutaneous fistulae. The third type of enteral hyperalimentation, termed modular feeding solutions, is prepared by mixing commercially available protein, carbohydrate and/or fat products to yield a small-volume, high-calorie (2 Kcal/ml) source for patients on fluid or protein restriction (cardiac, hepatic, or renal disease) (Table 2).

Nasogastric, nasojejunal, esophagostomy, gastrostomy, and jejunostomy tubes are commercially available.[17, 18] Nasoenteral tubes are used most frequently. The newer, thin, flexible tubes are well tolerated and are not associated with the complications of esophagitis, rhinitis, and parotitis seen with large bore N-G tubes.[19] The insertion is simple and may be facilitated by a variety of techniques.[20]

To hyperaliment a patient by the enteral route, the patient must tolerate a volume of solution that will deliver adequate calories. When necessary, a supplemental infusion of 1000 to 1500 ml/day of Isaac's 900 milliosmolar peripheral intravenous solution will convert a maintenance enteral regimen to a repletion program.[21] Peripheral intravenous lipid solution adds calories and supplies essential fatty acids to the regimen.[22]

Guidelines to ensure the successful utilization of this treatment regimen include: solution administration over 18 to 24 hours, preferably by pump; increasing the formula concentration and flow rate over 3 to 4 days; elevating the head of the bed; proper labeling of all solutions.[19, 23, 24]

Patients should be monitored closely to avoid fluid and electrolyte imbalances. These occur infrequently and can be easily treated. Daily weights and serum electrolytes; urea and glucose every 2-3 days; and urine glucose 3 times daily are required. Obstruction of the tube is the only mechanical problem occurring with frequency (less than 10%); this can usually be cleared with a saline flush. Gastrointestinal symptoms are usually avoided by application of the aforementioned guidelines. Essential fatty acids must be added orally or by vein to prevent a deficiency syndrome.[16]

2. The Parenteral Route

When enteral, or enteral plus peripheral therapy is inadequate for the excessive needs of a severely injured individual, central hyperalimentation is the

TABLE 2 — EXAMPLE OF A MODULAR ENTERAL SOLUTION USED IN REVERSING THE CACHEXIA OF A CIRRHOTIC, ENCEPHALOPATHIC PATIENT WITH ASCITES*

Product	CC	mOsm/kg	Kcal	Carbohydrate gm	Protein gm	Fat gm	Na mg
Magnacal (Organon)	570	520	1136	142	40	45	568
Polycose (Ross)	130	850	260	61			75
MCT (Mead Johnson)	50		415			50	
Total	750	543	1811	203	40	95	643

* Vitamin and mineral supplement should be given daily.

mainstay of therapy. The large central veins readily dilute these hyperosmolar formulas, preventing chemical phlebitis. Most solutions currently available contain a carbohydrate source, along with nitrogen in the form of crystalline amino acids or protein hydrolysate. The final solution will usually deliver approximately 1 Kcal/ml and 45 gm of protein per liter. It is important to order trace minerals (Zn, Mn, Co, N, I) and vitamins daily, as well as essential fatty acids weekly.

Central intravenous hyperalimentation, when performed by an experienced health care team, is a relatively safe procedure. Aseptic technique has decreased the rate of catheter infection to less than 7% in current studies.[25, 26] Because catheter insertion is an elective procedure, it should be performed under optimal conditions. Access to the subclavian vein may be achieved through a subclavicular, internal jugular, or external jugular approach. All of these techniques are described elsewhere in detail.[27, 28, 29]

The solution is initially infused at 1 liter per day, then increased slowly over several days to the maintenance or repletion dose. Assessments of the patient's nutritional status are continued; daily weight, intake and output, and vital signs are routinely monitored. The patient is checked daily for fluid overload or signs of heart failure or sepsis. Fractional urines for glucose are checked every 6 hours; electrolytes, BUN, and blood sugar are sampled daily until the patient is stable, and then continued at weekly intervals. Liver biochemical levels and complete blood counts are monitored weekly.

Glucose intolerance may initially be observed, but this condition usually improves after several days with cautious increments in the infusion rate. Should hyperglycemia persist, regular insulin may be given subcutaneously or added directly to the solutions as needed.

The complications related to central hyperalimentation fall into three categories. The first includes technical difficulties arising at the time of catheter placement: pneumo-, hemo-, and hydrothorax; air or catheter embolism; and carotid artery and brachial plexus injury. The second category of complications — infection and sepsis — may arise during the course of hyperalimentation. Scrupulous care of the catheter site reduces the chances of sepsis significantly. The third category — metabolic complications — comprises a lengthy list which can be avoided by careful monitoring. Hyperglycemia, glucosuria, hyperosmolar coma, and deficiency syndromes (i.e. vitamins, minerals, etc.) have all been noted. Hyper- and hyponatremia and low serum levels of potassium, magnesium, and phosphate can be corrected by adjusting the concentrations in the intravenous solution.[25]

Nutritional assessment should continue during and after the hyperalimentation program. Body weight, anthropometric measurements, and biochemical indices should be monitored throughout the patient's hospital stay. In addition, further consideration needs to be addressed to the nutritional care plan after the patient is discharged.

Nutritional support at home can take three forms: total parenteral hyperalimentation (TPH), nasogastric tube feedings, or an oral diet (which may include a variety of nutritional supplements). A patient receiving home TPH requires intensive education by the health care team members (nurse, pharmacist, physician, and dietician) several weeks prior to discharge.[30] Follow-up home visits are desirable and are currently practiced by several nutritional support services in Georgia.*

Patients receiving enteral hyperalimentation (oral and/or nasogastric feedings) at home should be instructed by the dietician prior to discharge. These patients can readily be taught to safely insert the nasogastric tube by themselves. The goal with this type of patient is to wean them slowly from tube feedings while increasing their oral intake. Telephone conversations (or home visits) are needed to evaluate the patient's repletional progress. A diet diary is useful in evaluating patient's intake at home.

Summary

The patient suffering from a severe traumatic injury is usually hypermetabolic and subsequently experiences rapid catabolism of body energy stores.

*Southeastern Medical Specialists Corporation and the VA Hospital, Home Based Care Unit, Atlanta, GA.

Recognizing those persons who are likely to develop protein calorie malnutrition is dependent on the accurate assessment of their pre-injury nutritional status along with an estimation of their increased daily caloric needs. The recent developments in new products and techniques to meet the nutritional requirements of these patients have greatly decreased their morbidity and mortality.

References

1. Cuthbertson D, Tilstone WJ. Metabolism during the post-injury period. Adv Clin Chem 1969;12:1-55.
2. Long CL. Energy balance and carbohydrate metabolism in infection and sepsis. Am J Clin Nutr 1977;30:1301-1310.
3. Wilmore DW, Pruitt BA. Parenteral nutrition in burn patients. In: Fischer JE (ed): Total Parenteral Nutrition. Boston, Little Brown and Co., 1976; Chap 14, pp 231-251.
4. Moore FD. Metabolic Care of the Surgical Patient. Philadelphia, W. B. Saunders Co 1959.
5. Meguid MM, Brennan MF, Aoki TT, Muller WA, Ball MR, Moore FD. Hormone-substrate interrelationships following trauma. Arch Surg 1974;109:776-783.
6. Lehninger AL. Biochemistry, ed 2. New York, Worth Publishers Inc., 1976.
7. Bistrian BR, Blackburn GL, Scrimshaw NW, Flatt JP. Cellular immunity in semi-starved states in hospitalized adults. Am J Clin Nutr 1975;28:1148-1155.
8. Butterworth CE, Blackburn GL. Hospital malnutrition and how to assess the nutritional status of a patient. Nutr Today Inc 1974;9:1-11.
9. Heymsfield SB, Olafson RP, Kutner MH, Nixon DW. A radiographic method of quantifying protein-calorie undernutrition. Am J Clin Nutr 1979;32:693-702.
10. Meador CK, Kreisberg FA, Friday JP, Bowdoin B, Coan P, Armstrong J, Hazelrig JB. Muscle mass determination by isotopic dilution of creatinine. Metabolism 1968;17:1104-1108.
11. Forbes GB, Bruining GJ. Urinary creatinine excretion and lean body mass. Am J Clin Nutr 1976;29:1359-1366.
12. Alpers DH, Isselbacher KJ. Derangements of hepatic metabolism. In: Thorn GW, Adams RD, Braunwal E, Isselbacher KJ, Petersdorf RG (eds): Harrison's Principles of Internal Medicine, ed 8. New York, McGraw-Hill Book Co., 1977, Chap 296, pp 1576-1580.
13. Garrow JS. Methods for measuring energy intake and output: their use and misuse. In: Energy Balance and Obesity in Man. New York, North-Holland Publ Co 1976; Chap 3, pp 47-91.
14. Flatt JP, Blackburn GL. The metabolic fuel regulatory system: implications for protein-sparing therapies during caloric deprivation and disease. Am J Clin Nutr 1974;27:175-187.
15. Greenberg GR, Marliss FB, Anderson GH, Langer B, Spence W, Tovee EB, Jeejeebhoy KN. Protein-sparing therapy in postoperative patients: effects of added hypocaloric glucose or lipid. NEJM 1976;294:1411-1456.
16. Heymsfield SB, Bethel R, Ansley J, Rudman D. Enteral hyperalimentation: an alternative to central venous hyperalimentation. Ann Intern Med 1979;90:63-71.
17. Graham WP III, Royster HP. Simplified cervical esophagostomy for long-term extraoral feeding. Surg Gynecol Obstet 1967;125:127-128.
18. Delany HM, Carnevale NJ, Garvey JW. Jejunostomy by a needle catheter technique. Surgery 1973;73:783-790.
19. Hoffmeister JA, Dobbie RP. Continuous control pump-tube feeding of the malnourished patient with Isocal. Am Surg 1977;43:6-11.
20. Bethel RA, Jansen RD, Heymsfield SB, Ansley JD, Hersh T, Rudman D, Nasogastric hyperalimentation through a polyethylene catheter: an alternative to central venous hyperalimentation. Am J Clin Nutr 1979;32:112-120.
21. Isaacs JW, Millikan WJ, Stackhouse J, Hersh T, Rudman D: Parenteral nutrition of adults with 900 milliosmolar solution via peripheral veins. Am J Clin Nutr 1977;30:552-559.
22. Wilmore DW, Joseph MC, Moyland A, Helmkamp GM, Pruitt BA, Jr. Clinical evaluation of a 10% intravenous fat emulsion for parenteral nutrition in thermally injured patients. Ann Surg 1973;178:503-513.
23. Kaminski MV. Enteral hyperalimentation. Surg Gynecol Obstet 1976;143:12-16.
24. Page CP, Ryan JA, Haff RC. Continual catheter administration of an elemental diet. Surg Gynecol Obstet 1976;142:184-188.
25. Ryan JA. Complications of total parenteral nutrition. In: Fischer JE (ed): Total Parenteral Nutrition. Boston, Little Brown and Co. 1976, Chap 4, pp 55-100.
26. Maki DG. Preventing infection in intravenous therapy. Hospital Practice. Anesth Analg 1977;56:141-153.
27. Garcia JM, Mispireta LA, Pinho RV. Percutaneous supraclavicular superior vena caval cannulation. Surg Gynecol Obstet 1972;134:839-841.
28. Jernigan WR, Gardner WC, Mahr MM, Milburn JL. Use of internal jugular vein for placement of central venous catheter. Surg Gynecol Obstet 1970;130:520-524.
29. Blitt CD, Wright WA, Petty WC, Webster TA. Central venous catheterization via the external jugular vein. JAMA 1974;229:817-818.
30. Solassol C, Joyeux H. Ambulatory parenteral nutrition. In: Fischer JE (ed): Total Parenteral Nutrition. Boston, Little Brown and Co 1976; Chap 16, pp 285-301.

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



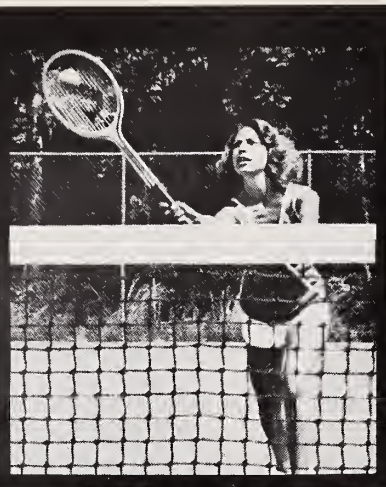
THE ULTIMATE DRIVING MACHINE.

BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730






Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

AIR ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

CHOPPER ONE



MICU 101



- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

METRO

AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

—— **CALL TOLL FREE** ——

EORGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
© WEIGHT WATCHERS INTERNATIONAL, 1977

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Tenuate® Ⓒ
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema, *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

9-4672 (Y957A)

Overweight may not always be simple... complications can develop.*
Complicated or not...

Tenuate® Dospan® ℂ IV
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

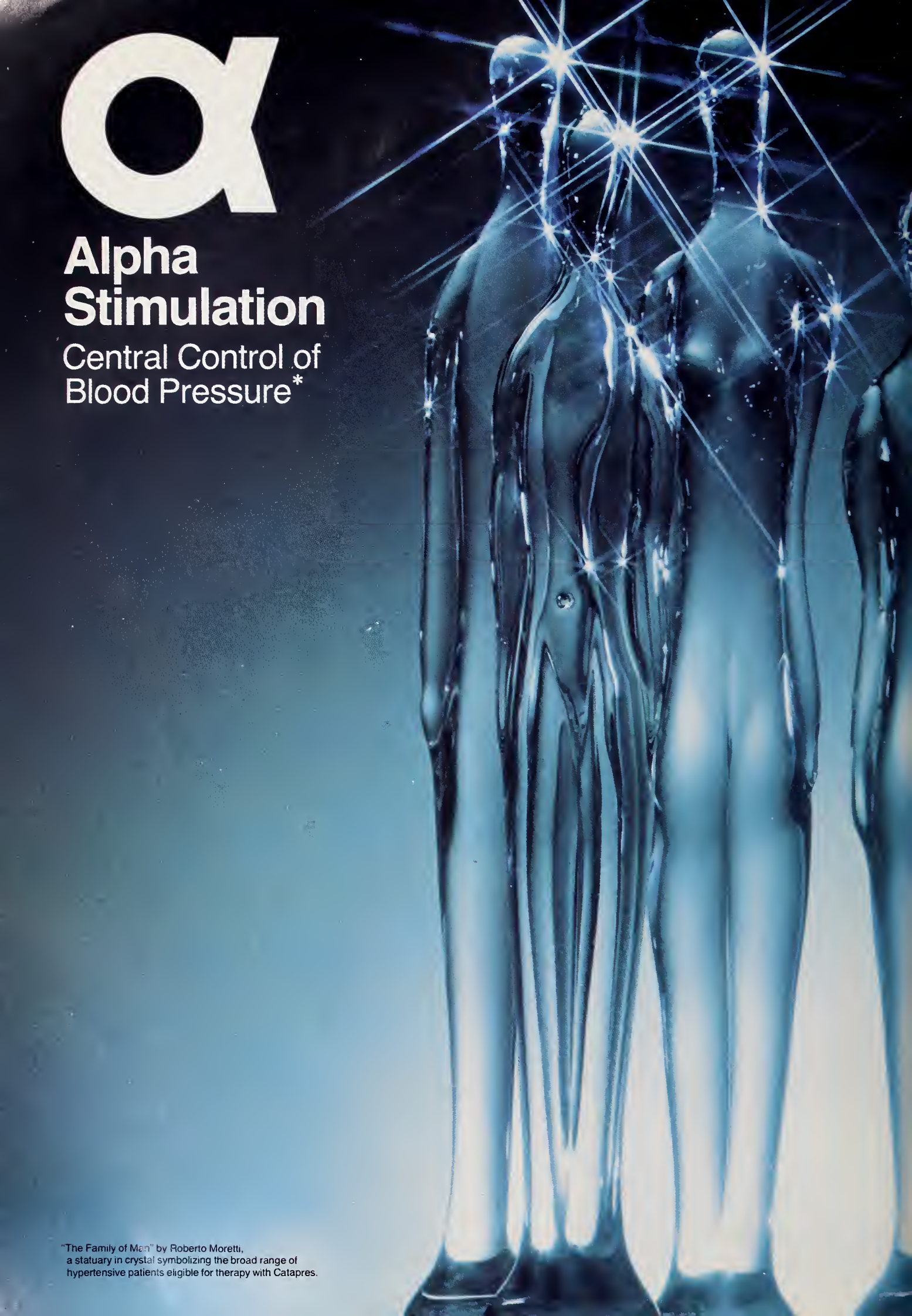
*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

Alpha Stimulation

Central Control of Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

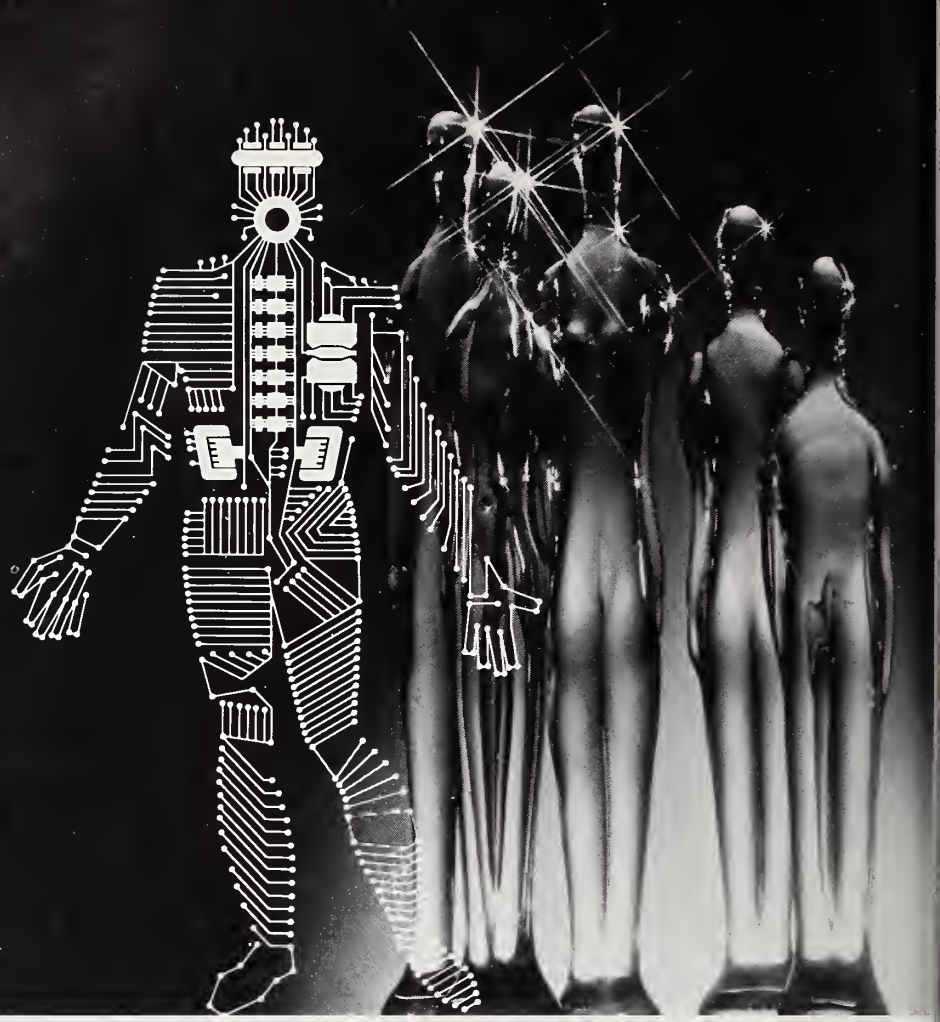
Now available in new 0.3 mg tablets

Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension

The Alpha Advantage:

It's for all kinds of hypertensives



Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness ar sedation. Constipation, dizziness, headache, and fatigue have been reporte Generally these effects tend to diminish with continued therapy. The followir reactions have been associated with the drug, some of them rarely. (In sor instances an exact causal relationship has not been established.) These includ Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities liver function tests; one report of possible drug-induced hepatitis without icter and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlc thalidone and papaverine hydrochloride. Weight gain, transient elevation of bloc glucose, or serum creatine phosphokinase; congestive heart failure, Raynauc phenomenon; vivid dreams or nightmares, insomnia, other behavioral change nervousness, restlessness, anxiety and mental depression. Also rash, a gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associate with a rash, impotence, urinary retention, increased sensitivity to alcohol, drynes itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomasti weakly positive Coombs' test, asymptomatic electrocardiographic abnormalitie manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or a sent reflexes and vomiting followed the accidental ingestion of Catapres (clonidir hydrochloride) by several children from 19 months to 5 years of age. Gastr lavage and administration of an analeptic and vasopressor led to complete r covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minu intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) ove dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 m (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Als available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

Boehringer Ingelheim
Boehringer Ingelheim Ltd
Ridgefield, CT 06877

In addition to describing the role of genetic susceptibility, the author discusses whether a shift in the pressure natriuresis curve of the kidney affects onset of hypertension.

Salt and Hypertension

LOUIS TOBIAN, M.D., Minneapolis, Minnesota*

THERE IS a considerable body of evidence that salt intake is related to hypertension.

Drastic reductions of sodium intake will definitely lower the blood pressure of patients with essential hypertension.[1-3] Diuretic agents, which facilitate the renal excretion of sodium, definitely reduce blood pressure in the majority of patients with essential hypertension.[4, 5] Concomitant high salt intakes can prevent this lowering of blood pressure.

Many populations in remote areas where individuals eat less than 30 mEq of sodium per day have virtually no hypertension at all, and moreover, have virtually no rise of blood pressure with advancing age.[6-11] These same people also eat a high potassium intake of about 200 mEq/day. Moreover, these people are not necessarily genetically resistant to hypertension, since it is well-documented that they begin to have their share of hypertension whenever they migrate into towns or acculturate to the ways of western civilization. Blood pressure also begins to rise with advancing age, subsequent to the acculturation.[7, 9, 12-14] The question naturally arises as to whether these people in remote areas have no hypertension because of their low sodium, high potassium intake, or because they are lean, because of their special psychosocial situation, or because of other nutritional deficiencies and debilitating diseases. There is good evidence that these various other factors are not responsible for the absence of hypertension. First of all, there are a few groups in widely separated areas (three continents) who have good nutrition and who lack debilitating disease, but still have no hypertension, namely the bushmen of the Kalahari Desert,[15] the Puka-pukans of the Cook Islands,[6] the Easter Islanders,[12] the Solomon Islanders,[7] and the Yanomamo Indians.[8] Furthermore, the absence of obesity is apparently not the decisive factor in preventing hypertension, since the Qash'qai nomads of Iran are similarly lean and similarly unacculturated but eat about 175 mEq of sodium per day and have a prevalence of hypertension similar to that of Caucasians in the United States. It is very difficult to measure psychosocial stress in primitive societies. However, one Solomon Island group cooked its food in sea water and had a sizeable sodium intake, as well as a 10% incidence of hypertension; while another coastal Solomon Island group, with very similar psychosocial behavior, steamed an almost identical diet with water from freshwater streams, thereby having a low sodium intake and a virtual absence of hypertension.[7] This very important observation suggests that psychosocial factors are not the decisive element in the absence of hypertension among people eating the very low salt intake. When the intake of sodium is below 30 mEq/day, there is almost no hypertension at all. When the intake of sodium is between 30 and 60 mEq/day, the incidence of hypertension is still probably below 3%, much lower than the 9 to 20% in the United States.[7]

There is fairly strong evidence that a really high sodium intake will increase the level of blood pressure. In a recent study at the University of Indiana, 800 mEq/day were fed to normotensive human volunteer subjects, and they showed a rise in blood pressure.[16] The increase became even greater when the subjects were given 1500 mEq/day. McDonough and Wilhelmj[17] fed one normotensive subject 600 mEq/day and produced a rise of blood pressure. McQuarrie et al.[18] studied a diabetic boy who had a great craving for salt. When he was allowed to eat 700 mEq of NaCl daily, he became hypertensive.

* Dr. Tobian is Professor of Internal Medicine and Chief, Hypertension Section, at the Department of Medicine, University of Minnesota, Minneapolis, MN 55455. This article is reprinted from *The American Journal of Clinical Nutrition*, 1979; 32:2739-2748.

When he was restricted to 85 mEq of NaCl daily, he became normotensive. Takahashi et al.[19] found a high incidence of hypertension and stroke in the Akita prefecture of Japan where people commonly have an intake of 425 mEq of NaCl daily. When the intake exceeds 360 mEq of NaCl daily, the death rate from strokes definitely increases. When the intake reaches 400 mEq/day, the death rate from stroke increases even more. Fodor et al.[20] also noted that a very high sodium intake among people in the coastal villages of Newfoundland was associated with a high prevalence of hypertension, compared to inland Newfoundlanders who did not eat as much salt fish and who had a much lower sodium intake. Shaper[21] reported that when the Samburu warrior-herdsmen were tending their herds and eating 50 mEq of sodium daily they had very little hypertension. However, when they were drafted into the army of Kenya, they began eating an army ration providing 308 mEq of NaCl daily. This sudden increase in sodium intake did not bring on a great rise of blood pressure during the first year. However, beginning with the second year of the high NaCl intake, blood pressure progressively rose during the second and third year. Numerous studies have shown that human subjects with renal parenchymal disease have a marked tendency to a rise in blood pressure when they take in large amounts of NaCl. This tendency is even more strikingly evident in dialysis patients.[22, 23]

Only a fraction (9-20%) of people are genetically susceptible to developing essential hypertension by middle life. The remainder are genetically resistant.

In the "middle range" of sodium intake usually encountered in industrialized western societies (90 to 200 mEq of sodium per day), intrapopulation studies have usually failed to show a strong relationship between individual blood pressure and sodium excretion in either white or black populations in the United States or elsewhere. Dawber et al.[24] found no correlation in the Framingham population. Langford and Watson[25] found none in Mississippi. Miall found a negative correlation in Wales.[26] Simpson et al.[27] found only a slight correlation in New Zealand.

Most of these studies have been based on a single 24-hr urine collection. Langford and Watson[25] showed that there is wide variation in sodium excretion from day to day, but even 6-day excretions failed to correlate with blood pressure. It appears that this level of sodium in the diet is sufficient to permit the expression of hypertension in genetically susceptible individuals in these socieites and is not sufficient to bring on hypertension in the far more numerous genetically resistant subjects. With these premises, no correlation would be expected.

Provocative animal experiments have also been performed. Lenel et al.[28] made chickens hypertensive by offering only 1% saline solution for drinking water. Sapirstein et al.[29] made rats hypertensive by allowing them to drink only a 2% saline solution. In the classic experiment of Menelly and Ball,[30] various diets containing salt in very small or very large amounts and with various intermediate levels were fed to rats over a 9-month period. It was seen that each increment in salt intake brought a concomitant increase in blood pressure. The rats eating the 10% salt in the dry diet developed frank hypertension. At 2 to 5% salt in the diet, borderline or mild hypertension was observed. At the higher levels of blood pressure, obvious nephrosclerosis was encountered. Potassium feeding reduces the hypertension resulting from concomitant NaCl feeding. In these early days, it was also clear that the full expression of deoxycorticosterone hypertension in the rat could best be obtained if a high NaCl intake were given along with the deoxycorticosterone. Conversely, a very low sodium intake completely prevented a rise in blood pressure after deoxycorticosterone. In the pig and in the dog also, high sodium feeding intensifies mineralocorticoid hypertension, while a very low sodium intake completely prevents it. Moreover, a high sodium intake, by itself, without concomitant mineralocorticoid will lead to hypertension in the pig and in the monkey. After removal of 70% of renal mass, the dog also can be made hypertensive by high NaCl feeding.

A Working Hypothesis Concerning the Mechanisms Relating Sodium to Hypertension

On a moderately high NaCl intake, some human subjects are hypertensive, and others are not. As mentioned previously, on a very low sodium intake (less than 30 mEq/day), all human subjects have normal blood pressures. Dahl et al.[31] was aware of this situation and created through selective inbreeding two strains of rats which mimic the human situation. When his two strains are both eating a low salt diet, they both have pressure levels within the normal range, thus resembling people living in remote regions and eating a low Na diet.[31] However, when the two strains are challenged with a daily high NaCl intake, the "S" strain shows its susceptibility to salt hypertension by gradually becoming severely hypertensive.[31] The "R" strain shows its great resistance to salt hypertension by having no rise in blood pressure whatsoever. Thus, the two strains again mimic civilized human subjects on a high-salt diet.

Thus, a good working hypothesis could be that human beings, like Dahl rats, are either genetically

susceptible or resistant to hypertension. The resistant ones do not get hypertension despite the usual lifelong consumption of 200 mEq of NaCl daily. The susceptibile ones also do not become hypertensive if their usual lifelong consumption is less than 60 mEq of NaCl daily. If susceptible human beings become hypertensive only when they eat generous amounts of NaCl, we must assume two links in the chain of causation. First, there must occur some initial accumulation of Na or Cl in the body. Second, this initial accumulation of body Na must lead to a rise in arterial pressure. We have clinical evidence for this second link in the chain. Subjects with disease of the renal parenchyma tend to retain body Na as they come into Na balance, and they often develop hypertension. Patients with an adenoma that puts out too much aldosterone tend to retain Na, and they frequently become hypertensive. When dialysis patients retain Na, they usually become hypertensive. Onesti et al.[32] purposefully raised the level of body Na in the course of dialysis treatment, and most subjects had a rise in pressure. When body Na was brought down to normal, blood pressure returned to normal. In these studies, when an increase in body Na raised blood pressure, in 60% of cases, the rise in pressure was entirely due to an increase in peripheral resistance with no hint of even a transient increase of cardiac output. In 20% of cases, the rise in pressure was entirely due to a rise in cardiac output with no hint of an increase in peripheral resistance to subserve a whole body autoregulation. In the last 20% of cases, the rise in blood pressure resulted from both an increase in peripheral resistance and an increase in cardiac output. The diseased kidneys had been removed in many of these dialysis patients, so kidneys were not necessary in these Na-induced blood pressure rises. The study also indicates that "volume" hypertension in these patients is actually "vasoconstriction" hypertension, at least in 80% of these subjects. This pressor response is not an invariable one. In six normotensive subjects with end-stage renal disease, raising body Na did not increase blood pressure at all. This probably explains why they remained normotensive as their kidneys were gradually being destroyed. Thus, Na accumulation in the body does not invariably raise blood pressure. In order to get Na-induced hypertension, this pressor response to Na accumulation must be present.

Limitation of NaCl intake to 60 mEq per day will prevent the onset of hypertension.

Now to discuss the first link in the chain of causal events: It would seem logical to assume that in order to get Na-induced hypertension, there would have to be some initial accumulation of Na in the body, which would in turn bring about a rise in pressure. Susceptible human subjects or susceptible S rats could be different from resistant men and rats because they initially retain more Na when exposed to a salt challenge. However, human hypertensives do not have an excess Na content in the body as a whole, though they do have an increased content of Na in the arterial walls. Similarly, Dahl S rats do not have excessive body Na levels either on high or low Na diets. Moreover, when these men or rats with established hypertension are challenged with a Na load, they excrete the Na very expeditiously, actually a bit faster than the normotensive controls. Thus, they appear to have no problem in handling a Na challenge. However, there is a consideration that perhaps makes these superficial conclusions invalid. The hypertensive kidney is perfused at an elevated pressure, while the normotensive kidney is perfused at a normal pressure. Selkurt[33] clearly showed in 1951 that high perfusion pressure in the renal artery greatly facilitates the urinary excretion of Na and urine volume. Thus, the intrinsic ability of kidneys to excrete Na cannot be validly compared when one kidney is perfused at high pressure and the other at normal pressure. To get at this perplexing question Tobian et al.[34] used isolated, blood perfused kidneys from the two contrasting strains of Dahl rats, which are good models for human hypertension and normotension. Both strains had been eating a low Na diet and hence had blood pressures within the normal range.

Figure 1 gives the urinary Na excretion per 100 g of isolated kidney per minute at various inflow pressures. The *top line* shows the mean values of isolated kidneys from 23 hypertension-resistant R rats. As expected, the Na output markedly increases with each increment of inflow pressure. The *bottom line* gives the average values of isolated kidneys from 29

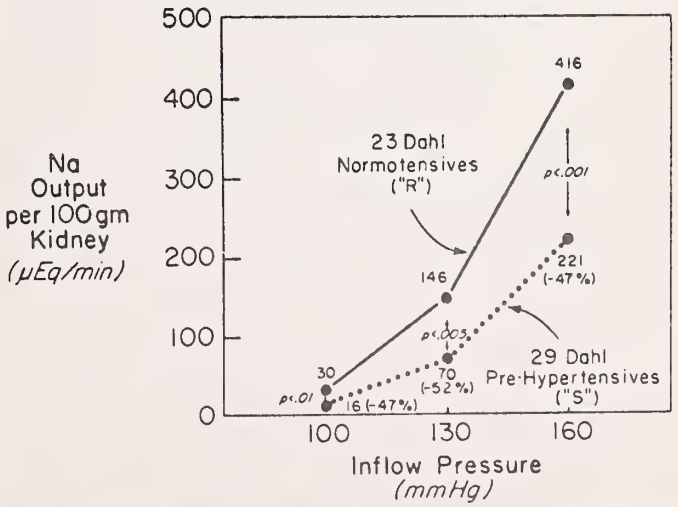


Figure 1 — Sodium excretion of isolated kidneys from S and R rats at varying inflow pressures. The distance between the large *black dot* (the mean value) and the tip of the *arrowhead* represents the SEM.

hypertension-prone S rats. These kidneys also show the pressure natriuresis phenomenon with more Na excreted for each increment of inflow pressure. However, it is obvious that there is a striking difference between S and R kidneys. For instance, at a normotensive inflow pressure of 130 mm Hg, the R kidneys excreted a mean of 146 μEq of Na per minute per 100 g of kidney, whereas at the same pressure the S kidneys averaged only 70 μEq. Thus, at 130 mm Hg inflow pressure, the S kidneys from hypertension-prone rats excreted 52% less Na than comparable R kidneys. This difference was significant ($P < 0.005$). At 160 mm Hg infusion pressure, we see the same phenomenon — the R kidneys averaging 416 μEq of Na excretion, whereas the S kidneys averaged only 221. This is a 47% reduction of Na excretion in S kidneys compared to R kidneys ($P < 0.001$). At 100 mm Hg inflow pressure, we see the same pattern, with the R kidneys excreting 30 μEq/min, while the S kidneys are excreting only 16. Hence, at 100 mm Hg inflow pressure, the S kidneys excreted 47% less Na than the R kidneys ($P < 0.01$).

The intrinsic ability of kidneys to excrete Na cannot be validly compared when one kidney is perfused at high pressure and the other at normal pressure.

When compared on an equal pressure basis, the S kidneys seem to have a very pronounced natriuretic handicap at all three inflow pressures. However, raising the inflow pressure can completely overcome this natriuretic handicap. For instance, the S kidneys perfused at 160 mm Hg excrete about 50% more Na per minute than the normotensive R kidneys perfused at a normal 130 mm Hg.

One can consider that the pressure natriuresis curve of the S rat has been shifted to the right. This amounts to a "resetting" of the curve so that it takes a greater level of inflow pressure to bring about a given rate of natriuresis.

At a normal inflow pressure, the renal blood flow and glomerular filtration rate of the S and R rats were not significantly different. These studies indicate that the isolated kidneys from S rats excrete only half as much Na as kidneys from R rats, when the two contrasting strains are compared at equal levels of inflow pressure. Thus, the hypertension-prone S strain appears to have a resetting of the pressure natriuresis curve, in that a higher inflow pressure is required to achieve a given Na excretion. This occurs even though the S kidney has no pathologic lesions. In either strain on a very low Na intake, there would be virtually no tendency for Na retention and hence little stimulus for a rise in blood pressure beyond the normal range. However, when the S rats begin a high Na intake, the resetting of the pressure natriuresis curve could then conceivably become an important factor. If the relative rates of natriuresis of isolated S and R kidneys occurred in the intact rat during the high Na intake, the S rat would tend to retain more sodium than the R rat and would tend to come into Na balance with an elevated body Na and extracellular volume. Such high body Na and extracellular volumes frequently bring on a rise in blood pressure, as is commonly seen in the hypertensions of renal parenchymal disease, mineralocorticoid excess, and in dialysis patients. If the arterial pressure did rise into the hypertensive range, the S kidney would then increase its rate of Na excretion through the mechanism of a pressure natriuresis, and its natriuretic handicap would be overcome. With the raised arterial pressure, the kidney could then excrete Na rapidly enough to permit attainment of Na balance at a normal extracellular volume. The natriuretic handicap would then seem to disappear and renal excretory function would appear to be normal. Assuming a possible resetting of the pressure natriuresis curve for the intact, in vivo, S kidney, the S rat would tend to become hypertensive when on a high Na intake, which would in turn produce natriuresis that would bring to normal its body Na content. If the accumulation of body Na did not induce the pressor response, as was observed in some of Onesti's patients, then Na balance would occur with a somewhat elevated level of body Na and a normal blood pressure. This would be a relatively unusual physiologic response.

The experiments of Iwai et al.[35] provide some evidence that there may indeed be an in vivo difference in pressure natriuresis curves between S and R rats. When these two contrasting strains were fed a high NaCl intake, the feeding of chlorothiazide significantly increased urinary Na excretion in S rats but had no effect on Na excretion in R rats. Moreover, when the chlorothiazide was discontinued after some weeks, the Na excretion significantly dropped in S rats while rising slightly in R rats. The findings could be interpreted as indicating that the R kidneys have a pressure natriuresis curve favoring very rapid natriuresis at relatively low inflow pressures, such that adding chlorothiazide will not make an already rapid natriuretic capacity even more rapid. However, if there existed an in vivo resetting of the pressure natriuresis curve in S rats favoring a slower rate of natriuresis, then adding chlorothiazide might have the effect of shifting the natriuresis curve of the S kidney to the left, thereby making Na excretion more rapid. The contrasting effect of thiazide on Na excretion in these two strains could be accounted for by this mechanism.

This formulation could conceivably account for much of the exquisite sensitivity to NaCl-induced hypertension in the Dahl S rat. It is pertinent to

wonder whether the kidneys of patients with essential hypertension might also have a resetting of the pressure natriuresis curve in favor of hypertension. Future studies will be needed to answer this question.

The hypothesis that an intrinsic shift in the pressure natriuresis curve can lead to rat hypertension or even human hypertension certainly fits well with the action of diuretic drugs in reducing hypertensive pressure levels. Many diuretic agents are extremely effective in man in reducing high blood pressure.

Potassium feeding reduces the hypertension resulting from concomitant NaCl feeding.

The same is true for the Dahl S rat. This would make physiological sense. If a diuretic agent were given to an S rat it would facilitate natriuresis and would tend to overcome the intrinsic defect in natriuresis which these rats have. In the presence of daily diuretic therapy, the body Na level comes into balance at a slightly lower than normal level. This should remove the previous Na stimulus leading to elevate pressure levels, and blood pressure should begin to drift toward normal levels. In the presence of a diuretic, an elevated pressure level would no longer be needed in S rats to facilitate natriuresis. Such a mechanism could explain the powerful anti-hypertensive action of diuretic agents.

In order to investigate some of these possibilities, Tobian et al.[36] did a study in Dahl rats using a thiazide diuretic, methyclothiazide (Fig. 2) to test another facet of the sodium hypothesis. Half of the rats in each strain were given the thiazide diuretic. All rats were given a low Na diet for the first 14 weeks. If the rat tends to retain Na and become hypertensive on an 8% NaCl diet because of the shift in his pressure natriuresis curve, then a thiazide diuretic should be able to prevent the Na retension, and the rise in blood pressure should be averted. This had never been demonstrated until this study. Where one sees the *vertical line* on Figure 2, all the rats began eating the 8% NaCl diet while half of them remained on thiazide. The group of S rats *not* on thiazide showed a prompt rise of blood pressure with a steady climb to 210 mm Hg by the eighth week of the 8% NaCl diet. The R rats not on thiazide had no rise in pressure whatsoever, as expected. Moreover, the R rats on thiazide had the same pressure as the R rats not on thiazide. Of great interest was the observation that the S rats on thiazide had virtually the same blood pressure as the R rats. The thiazide had almost completely prevented any Na-induced rise in blood pressure in the S rats, the pressure only going up five mm Hg above that of the R rats after 9 weeks of an 8% NaCl diet. Seemingly, if body Na retention is prevented by thiazide, there is no rise in pressure in S rats despite the very high 8% NaCl intake and the intrinsic limitation of natriuresis.

In an attempt to explain the reduced sodium excretion of S kidneys, Tobian et al.[34] recently searched for sodium-retaining hormonal agents in S rats. When the blood of S rats is perfused through normal "neutral" isolated kidneys at 125 mm Hg, the neutral kidney excretes only half as much sodium per minute, compared to similar perfusion of the neutral kidney with the blood of R rats ($P < 0.05$). Thus, S rats appear to have either a circulating antinatriuretic hormone or else they lack a natriuretic hormone, which partially accounts for the tendency to reduce sodium excretion of S kidneys.[37]

In other experiments, a circulating, blood-borne vasoconstrictor effect has been found in S rats that are developing hypertension after 4 weeks on a high salt diet.[38] This is not seen in R rats that have remained normotensive while eating the same high salt diet.

There are increasing amounts of evidence pointing to a role of the central nervous system in NaCl-induced hypertension. Takeshita and Mark[39] found an increased vascular resistance in Dahl S rats that had become hypertensive after 1 month of a high NaCl intake. When they cut the sympathetic nerves to the hindquarters of these hypertensive rats, half of the increase in vascular resistance was thereby abolished. This points to sympathetic nerve participation in the NaCl-induced increase in vascular resistance. One group destroyed the peripheral sympathetic nerves in Dahl S rats.[40] After this destruction, the feeding of a high NaCl diet did not bring about a rise in blood pressure, pointing to a participation of the

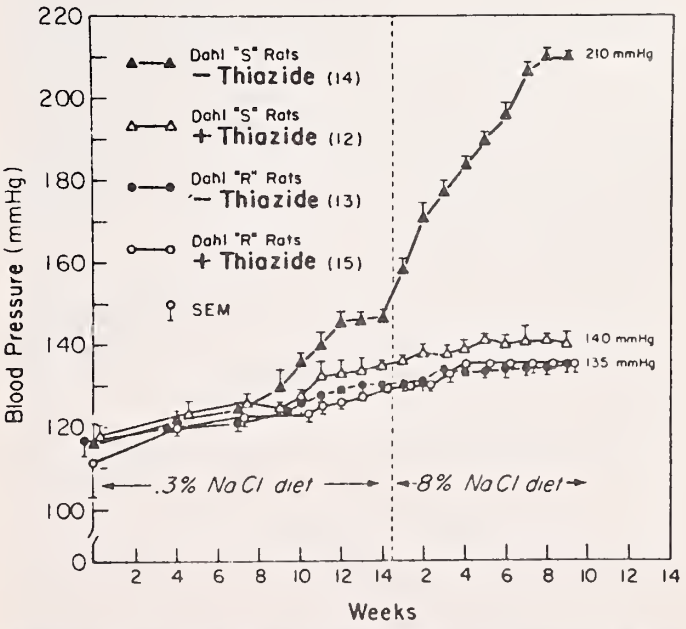


Figure 2 — Effect of a thiazide diuretic, methyclothiazide, on the development of hypertension in Dahl S and R rats fed normal and high NaCl diets.

sympathetic nervous system in this hypertension. Ikeda and Tobian[41] induced pressor responses in normotensive Dahl S and R rats by the introduction of a hypertonic NaCl solution and the introduction of angiotensin II into the lateral ventricle of the brain. With both of these central nervous system pressor stimuli, the rise in blood pressure was twice as great in the S rats as in the R rats, even though the baseline blood pressure was similarly normotensive for both groups. These results certainly indicate enhanced central nervous system pressor responses in the S rats, which could partially contribute to their heightened susceptibility to NaCl-induced hypertension. Ikeda and Tobian[38] have very recently introduced 6-hydroxydopamine into the lateral brain ventricle of Dahl S rats in order to cause destruction of many central adrenergic neurons. These S rats were subsequently placed on a high NaCl diet and had only half the rise in blood pressure that the pair-fed sham-operated control S rats experienced (L. Tobian, Jr., unpublished observations). Again this would indicate the participation of central adrenergic neurons in NaCl-induced hypertension.

Physiologic Requirements for Dietary Sodium

Habitual intake of sodium appears to bear no relationship to physiologic need. Estimated daily losses of sodium in urine, stool, skin and insensible perspiration in subjects on a markedly restricted sodium intake total 2 to 8 mEq/day.[42]

Additional losses occur during sweating; however, sodium concentration in sweat is adjusted downward during sodium deprivation because of adrenocortical influences. Healthy individuals have been shown to maintain sodium balance on a sodium intake of less than 87 mEq/24 hr while sweating 9 liters/day.[43] A variety of preindustrial societies, in widely divergent habitats (tropical jungle, desert, arctic, etc.) subsist for generations on sodium intakes less than 43 mEq/day and show no evidence of sodium deprivation.[7, 42] Total body sodium content is about 5652 mEq for a 70-kg man.[44]

Requirements for sodium in growing infants and children are estimated at less than 9 mEq/day.[45]

It thus appears that the habitual intake of sodium in adults in the United States often exceeds body need by 10-fold or more.

Since adult fluid intake averages 1500 to 3000 ml/day, sodium intake from drinking water represents a very small fraction of the total sodium ingested in areas where sodium content of water does not exceed 1 mEq/liter. However, as sodium concentration in drinking water increases above this level, harmful effects may be anticipated in special risk groups restricted in total sodium intake.[46]

Sodium Restriction as a Component of the Treatment of Hypertension

As mentioned above, a sodium intake under 10 mEq/day will very often reduce high blood pressure. But such a diet is very difficult to follow for most people. However, there is also evidence that modest sodium restriction alone (60 to 90 mEq/day) can be effective in producing a small reduction of blood pressure.[47] This same modest sodium restriction enhances the antihypertensive effect of diuretic agents.[48] Winer[49] showed that large intakes of sodium could vitiate the antihypertensive effect of thiazide diuretics. Langford et al.[50] has shown that diuretics increase sodium appetite and intake in man. Advice to restrict intake would tend to counteract this. Brackett[51] has shown that propranalol alone has a far more potent antihypertensive action when combined with modest sodium restriction, whereas it has a very weak antihypertensive action when combined with a high sodium intake. In the usual patient with hypertension associated with renal parenchymal disease, modest sodium restriction is especially important in antihypertensive therapy. It reduces sodium intake to match the reduced nephron population.[52] Dahl[53] reported that obese hypertensives were especially benefited by a low-sodium diet in terms of blood pressure reduction. Mineralocarticoid hypertension in man is also helped by sodium restriction.[54] Joosens found a strong correlation of sodium intake and pressure in the elderly. This may relate to the physiologic reduction of renal function with advanced age. Weight reduction will lower the blood pressure of hypertensive patients; weight gain tends to raise their pressure. Obesity, in general, is strongly correlated with the presence of hypertension. Moreover, a recent study indicates that the antihypertensive effect of weight reduction is independent of a reduced sodium intake.[55] There is some preliminary evidence that an increased intake of potassium is correlated with a lower blood pressure level.[56]

Summary and Conclusions

Although the evidence is far from complete, a large body of information has accumulated linking hypertension to dietary sodium intake in human subjects. This evidence warrants some general conclusions.

The best current working hypothesis is that only a fraction of human subjects are genetically susceptible to developing essential hypertension by middle life. This varies between 9 and 20% of the population, depending on which segment of the American population is under study. The remainder of the population (80 to 91%) could be considered as genetically resistant to developing essential hypertension.

If an individual is among those genetically resistant to hypertension, he or she can eat as much as 200 mEq of NaCl daily without developing an elevated blood pressure.

However, if a person is among those genetically susceptible to hypertension, a lifelong modest restriction of NaCl intake to levels less than 60 mEq/day in adults will probably prevent the onset of the hypertension indefinitely, and also prevent all subsequent hypertensive complications. Unfortunately, there is no certain technique that will identify the individual persons that are susceptible to developing hypertension in middle life. We do know that certain individuals are at especially great risk for developing subsequent essential hypertension. They would include: a) individuals with a family history of hypertension; b) individuals with a blood pressure in the upper 20th percentile of the population, either in childhood, adolescence, or adulthood; c) individuals whose resting heart rate is considerably more rapid than would be expected from their state of physical conditioning; d) individuals who are more than 15% above optimal body weight.

This same modest dietary restriction of NaCl (less than 60 mEq/day) enhances the antihypertensive effect of all antihypertensive drugs and other measures in patients with established hypertension, from borderline levels on up.

It is clear that it requires a much lower level of Na intake to reduce established hypertension than to prevent the onset of hypertension. Limitation of intake to 60 mEq/day will prevent the onset of hypertension. It may require as little as 20 mEq/day to reduce severe hypertensive pressure levels. With mild hypertension, 40 to 50 mEq/day will often reduce blood pressure levels to a certain extent.

Intensive research is needed to discover a method for more certain identification of the specific individuals who are destined to become hypertensive in the future.

Control of body weight and correction of obesity are beneficial both in the prevention of hypertension for persons at risk and also in the reduction of blood pressure in persons with already established hypertension. Weight control should, therefore, be strongly recommended as prudent for all persons in all segments of society. The antihypertensive action of reducing obesity seemingly operates separately from the antihypertensive action of NaCl restriction.

References

1. Murphy RFJ. The effect of "rice diet" on plasma volume and extracellular fluid space in hypertensive subjects. J Clin Invest 1950;29:912.
2. Watkin DM, Fraeb HF, Hatch FT, Gutman AB. Effects of diet in essential hypertension. II. Results with unmodified Kempner rice diet in fifty hospitalized patients. Am J Med 1950;9:441.
3. Kempner W. Treatment of kidney disease and hypertensive vascular disease with rice diet. N Carolina Med J 1944;5:125.
4. Dustan HP, Cumming GR, Corcoran AC, Page IH. A mechanism of chlorothiazide enhanced effectiveness of antihypertensive ganglioplegic drugs. Circulation 1959;19:360.
5. Wilson IM, Freis ED. Relationship between plasma and extracellular fluid volume depletion and the antihypertensive effect of chlorothiazide. Circulation 1959;20:1028.
6. Prior IAM, Evans JG, Harvey HPB, Davidson F, Lindlsey M. Sodium intake and blood pressure in two Polynesian populations. New Engl J Med 1968;279:515.
7. Page LB, Danion A, Moellering RD Jr. Antecedents of cardiovascular disease in six Solomon Islands societies. Circulation 1974;49:1132.
8. Oliver, WJ, Cohen, EL, Neel JV. Blood pressure, sodium intake and sodium related hormones in the Yanomamo Indians, a "no-salt" culture. Circulation 1975;52:146.
9. Maddocks I. Blood pressures in Melanesians. Med J Australia 1967;1:1123.
10. Sinnett PF, Whyte HM. Epidemiological studies in a total highland population, Tukisenta, New Guinea. Cardiovascular disease and relevant clinical, electrocardiographic, radiological and biochemical finds. J Chronic Diseases 1973;26:265.
11. Truswell AS, Kennelly BM, Hansen JDL, Lee RB. Blood pressure of Kung bushmen in Northern Botswana. Am Heart J 1972;84:5.
12. Cruz-Coke R, Etcheverry R, Nagel R. Influence of migration on blood pressure of Easter Islanders. Lancet 1964;1:697.
13. Cruz-Coke R, Donoso H, Barrera R. Genetic ecology of hypertension. Clin Sci Mol Med 1973;45:(Suppl. I)55.
14 Lowenstein FW. Blood pressure in relation to age and sex in the tropics and subtropics. Lancet 1961;1:389.
15. Kaminer B, Lutz WPW. Blood pressure in Bushmen of the Kalahari Desert. Circulation 1960;22:289.
16. Murray RH, Luft FC, Block R, Weyman AE. Blood pressure responses to extremes of sodium intake in normal man. Proc Soc Exptl Biol Med 1978;159:432.
17. McDonough J, Wilhelmj CM. The effect of excessive salt intake on human blood pressure. Am J Digest Diseases 1954;21:180.
18. McQuarrie I, Thompson WH, Anderson JA. Effects of excessive ingestion of sodium and potassium salts on carbohydrate metabolism and blood pressure in diabetic children. J Nutr 1936;11:77.
19. Takahashi E, Sasaki N, Takeda J, Ito H. The geographic distribution of cerebral hemorrhage and hypertension in Japan. Hum Biol 1957;29:139.
20. Fodor JG, Abbott EC, Rusted IE. An epidemiologic study of hypertension in Newfoundland. Canad Med Assoc J 1973;108:1365.
21. Shaper AG. Cardiovascular disease in the tropics. III. Blood pressure and hypertension. Brit Med J 1972;3:805.
22. Ulvila JM, Kennedy JA, Lamberg JD, Scribner BH. Blood pressure in chronic renal failure: effect of sodium intake and furosemide. J Am Med Assoc 1972;220:233.
23. Vertes V, Cangiano JL, Berman LB, Gould A. Hypertension in endstage renal disease. New Engl J Med 1969;280:978.
24. Dawber TR, Kannel WB, Kagan A, Donabedian RK, McNamara PM, Pearson G. Environmental factors in hypertension. In: Stamler J, Stamler R, Pullman T, eds. The epidemiology of hypertension. New York: Grune & Stratton 1967:255.
25. Langford HG, Watson RL. Electrolytes and hypertension. In: Paul O, ed. Epidemiology and control of hypertension. New York: Stratton Intercontinental Medical Book Corp., 1975:119.
26. Miall WE, Oldham PD. Factors influencing arterial blood pressure in the general population. Clin Sci 1958;17:409.
27. Simpson FO, Waal-Manning HJ, Bolli P, Phelan EL, Spears GF. Relationship of blood pressure to sodium excretion in a population survey. Clin Axi Mole Med 1978;55:(Suppl.4)373s.
28. Lenel R, Katz LN, Rodbard S. Arterial hypertension in the chicken. Am J Physiol 1948;152:557.
29. Sapirstein LA, Brandt WL, Drury DR. Production of hypertension in the rat by substituting hypertonic sodium chloride solutions for drinking water. Proc Soc Exptl Biol Med 1950;73:82.
30. Meneely GR, Ball COT. Experimental epidemiology of chronic sodium chloride toxicity and the protective effect of potassium chloride. Am J Med 1958;25:713.
31. Dahl LK, Heine M, Tassinari L. Effects of chronic salt ingestion. Evidence that genetic factors play an important role in susceptibility to experimental hypertension. J Exptl Med 1962;115:1173.
32. Onesti G, Kim KE, Greco JA, Del Guercio ET, Fernandes M, Swartz C. Blood pressure regulation in end-stage renal disease and anephric man. Circ Res 1975;36,37:(Suppl I) I.
33. Selkurt EE. Effect of pulse pressure and mean arterial pressure modification on renal hemodynamics and electrolyte and water excretion. Circulation 1951;4:541.
34. Tobian L, Lange J, Azar S, Iwai J, Koop D, Coffee K, Johnson MA. Reduction of natriuretic capacity and renin release in isolated, blood-perfused kidneys of Dahl hypertension-prone rats. Circ Res 1978;43:I-92.
35. Iwai J, Ohanian EV, Dahl LK. Influence of thiazide on salt hypertension. Circ Res 1977;44:(Suppl I)131.
36. Tobian L, Lange J, Iwai J, Hiller K, Johnson MA, Goossens P. Prevention with thiazide of NaCl-induced hypertension in Dahl "S" rats: evidence for a Na-retaining humoral agent in "S" rats. Hypertension 1979;1:316.
37. Tobian L, Lange J, Iwai J, Hiller K, Johnson MA, Goossens P. Prevention with thiazide of NaCl-induced hypertension in Dahl "S" rats with NaCl hypertension. Hypertension 1979;1:3.
38. Tobian L, Pumper M, Johnson S, Iwai J. A circulating humoral pressor agent in Dahl "S" rats with NaCl hypertension. Clin Sci. In press.
39. Takeshita A, Mark AL. Neurogenic contribution to hindquarters vasocon-

striction during high sodium intake in Dahl strain of genetically hypertensive rats. Circ Res 1978;43:(Suppl I)I.
40. Takeshita A, Mark AL, Brody MJ. Prevention of salt-induced hypertension in Dahl strain by 6-hydroxydopamine. Am J Physiol 1979;236:H48.
41. Ikeda T, Tobian L, Iwai J, Goossens P. Central nervous system pressor responses in rats susceptible and resistant to sodium chloride hypertension. Clin Sci Mole Med 1978;55:225s.
42. Dahl LK. Salt intake and salt need. New Engl J Med 1958;258:1152.
43. Conn JW. Mechanism of acclimatization to heat. Advan Internal Med 1949;3:373.
44. Widdowson EM, McCance RA, Spray CM. Chemical composition of the human body. Clin Sci 1951;10:113.
45. American Academy of Pediatrics Committee on Nutrition. Salt intake and eating patterns of infants and children in relation to blood pressure. Pediatrics 1974;53:115.
46. White JM, Wingo JG, Alligood LM, Cooper GR, Gutridge J, Hydaker W, Benack RT, Dening JW, Taylor FB. Sodium ion in drinking water I. properties, analysis and occurrence. J Am Dietet Assoc 1967;50:32.
47. Parijs J, Joosens JV, Linden LV, Verstreken G, Amery AKPC. Moderate dosium restriction and diuretics in the treatment of hypertension. Am Heart J 1973;85:22.
48. Fallis N, Ford RV. Electrolyte excretion and hypotensive response. J Am Med Assoc 1961;176:581.
49. Winer BH. The antihypertensive actions of benzothiadiazines. Circulation 1961;23:211.
50. Langford HG, Watson RL, Thomas JG. Salt intake and the treatment of hypertension. Am Heart J 1977;93:531.
51. Owens CJ, Brackett NC Jr. The role of sodium intake in the anti-hypertensive effect of propranolol. Southern Med J 1978;71:43.
52. Hunt J. Management and treatment of essential hypertension. In Genest J, ed. Hypertension. New York: McGraw-Hill, 1977:1068.
53. Dahl LK, Silver L, Christie RW. The role of salt in the fall of blood pressure accompanying reduction in obesity. New Engl J Med 1958;258:1186.
54. Dustan HP, Bravo EL, Tarazi RC. Volume-dependent essential and steroid hypertension. Am J Cardiol 1973;31:606.
55. Reisen E, Abel R, Modan M, Silverberg DS, Eliahou HE, Modan B. Effect of weight loss without salt restriction on the reduction of blood pressure in overweight hypertensive patients. New Engl J Med 1978;298:1.
56. Walker G, Russell P, Whelton P, Hermann J. Relation between blood pressure, plasma renin activity, aldosterone, urinary sodium and potassium in 574 ambulatory subjects. Circulation 1978;58:(Suppl II)II.

NUTRITION SERVICES CENTER

PHYSICIAN REFERRAL
• Computerized Nutrition Analysis
• Diet Therapy by Clinical Nutrition Specialists
• Hospital Consults

Nutrition Services Center
Emory University School of Medicine
1712 Clifton Road
Atlanta, Georgia 30329
Telephone (404) 329-5737

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director
Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.
Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard



SOME MALPRACTICE INSURANCE POLICIES SETTLE FOR JUST ANYBODY.

Today, all too many people are finding it easy to sue. And unfortunately, all too many insurance companies are finding it easier on themselves to settle. Quickly and out of court. Little thought is given to defending your reputation.

In fact, your insurance company may not even give you an option to fight a claim. Or if you do have that option, you can be hit with a costly penalty for going to court.

And there are other ways your insurance company may not stand behind you. For instance, chances are to save costs and time your company will use a claims adjuster to handle your case. Not a lawyer.

It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working hard for doctors. We know the strong coverage and knowledgeable service physicians need from their liability insurance. And because we specialize in this one field, we can offer a superior policy at a realistic premium. Premiums based on actual costs in your state.

Don't settle for just any insurance. Get a policy that really stands behind you. Contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas phone 1-800-231-2615.

ICA INSURANCE CORPORATION OF AMERICA

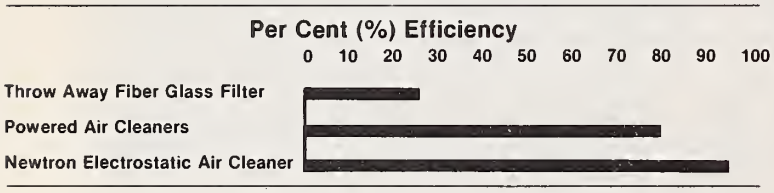
MALPRACTICE INSURANCE IS BETTER TODAY. BECAUSE OF ICA.

Doctor, your patients will be asking about the Newtron® Electrostatic Air Cleaner.



And with good reason. The Newtron® electrostatic air cleaner is a revolutionary new device that allows allergy patients to breathe clean air in their homes and offices — at a much lower cost than has ever been possible before.

In fact, the Newtron® is the only reasonable answer to the problems caused by pollen, dust, smoke, and other air pollutants. It requires no electricity, never needs to be replaced, requires no maintenance other than a monthly rinsing with tap water, and comes in standard filter sizes to simply replace the existing throw-away filter in heating and air conditioning systems. Even more importantly, it far out-performs all other cleaners, including electrically powered models costing more than three times as much.



In the past, high costs and complicated installation have put truly clean air out of the reach of most allergy patients. Now that the Newtron® is available — and has been proven effective in hospitals, businesses, private homes, and apartments — your patients will be asking for your approval or opinion.

Please allow us to send you a complete information package on the Newtron®. No salesman will call, either in person or by telephone (unless you request it). The price of the Newtron® varies from $195 to $205, according to size. (Master Charge® and VISA® are accepted.) Professional discounts on Newtron® electrostatic air cleaners are available to physicians who wish to purchase one unit for their personal use.

Newtron®

The ultimate air cleaner.

Clip and mail this coupon to

Newtron Sales
202 Nottingham Ln.
Slidell, La. 70458

Please send complete information on the Newtron® electrostatic air cleaner.

Dr. _____

Address _____

City _____ State: _____

Zip: _____

Specialty: _____

Newtron® is a registered trademark of Newtron Products Co., Cincinnati, Ohio
The generic name is electrostatic air cleaner

Nutrition curricula are being changed to better inform medical students about the role nutrition plays in the prevention and treatment of chronic and acute diseases.

Educating the Student, Informing the Physician on Nutrition

ELAINE B. FELDMAN, M.D., MAURICE LEVY, Ed.D., *Augusta*, and ROBERT H. CURRY, M.D., *Atlanta**

Nutrition is a discipline which has been neglected in the education and training of physicians despite its obvious importance in promoting health and in the causation or therapy of disease. The American Medical Association and the Association of American Medical Colleges have recently recognized this, and the principles and practice of clinical nutrition have been introduced into medical school curricula. Patient care (diagnosis and therapy) and the continuing education of physicians are also receiving increased emphasis. With the identification of vitamin deficiency diseases and their "cure," nutritional disorders have not been of interest in our affluent society. We now realize, however, that malnutrition also includes overnutrition, that diet-related diseases are major health hazards, that nutritional support should be a part of treatment of trauma, sepsis, cancer, etc., and that our knowledge of human nutritional requirements remains incomplete.

Nutrition Education in Medical Schools

A. Required

In 1978, only 30 medical schools in this country required their students to take a course in nutrition; and 106 schools incorporated the teaching of nutrition into other courses. A total of 84 schools offered elective courses in nutrition with 43 offering clinical clerkships in nutrition. Half the schools provided continuing medical education or opportunities for post doctoral training in nutrition.

1. Medical College of Georgia

At the Medical College of Georgia, nutrition is offered in two forms in required courses in the first 2 years: as part of other courses (Cell and Molecular Biology, Physiology, Physical Diagnosis, Community Medicine, Pharmacology), accounting for about two-thirds of the offerings, and the remainder in a "core" of nutrition in the course, "Introduction to Clinical Medicine." The nutrition component is coordinated by the Section of Nutrition, Department of Medicine. Elements of the principles of nutrition are introduced in a progressive manner, from micronutrients (vitamins and minerals), to macronutrients (proteins, carbohydrates, fats), and calories, and a review of the regulation of body composition. Anthropometric measurements and nutritional assessment are taught, as are public health and epidemiologic aspects of foods and nutrition. Hyperlipoproteinemias, atherosclerosis, obesity, protein-calorie malnutrition, and dietary fads comprise the core subjects. The therapeutic use of vitamins and minerals and parenteral nutrition conclude the basic science nutrition curriculum.

This basic nutrition core is provided to all medical students, 180 per class, primarily as lectures in a classroom setting. These sessions provide the essential information required for the application of nutritional principles to the diagnosis and treatment of disease. Not yet included in this curriculum is important information concerning the nutritional requirements and disorders of the elderly, hormone-fuel interactions, the role of nutrition in the etiology and

* Dr. Feldman is Professor of Medicine, Chief of the Section of Nutrition, and Director of the Georgia Institute of Human Nutrition at the Medical College of Georgia. Dr. Levy is Professor of Education Research and Director of the Division of Education Research and Development at the Medical College of Georgia. Dr. Curry is Associate Professor of the Allied Health Professions, Assistant Professor of Pediatrics, and Director of the Physician Associate Program at Emory University School of Medicine. Address reprint requests to Dr. Feldman at the Department of Medicine, Section of Nutrition, Medical College of Georgia, Augusta, GA 30912.

treatment of cancer and in the management of the patient with trauma or sepsis. For that reason, to enhance the exposure to nutrition courses and to recruit more physicians into this specialty, we have proposed that a new nutrition course be required for sophomore medical students. This course would supplement the nutrition material taught in the basic science courses and in essence replace and expand the nutrition core in "Introduction to Clinical Medicine." Additional instruction in variable formats would include topics concerning food toxicology and allergy, would provide an introduction to diet therapy of diseases, such as diabetes mellitus, renal and hepatic failure, alcoholism, and would review nutrition in the life cycle prior to the student's clinical experiences.

Students in the medicine clerkship learn the use of special diets in the treatment of hyperlipidemia, diabetes mellitus, malabsorption, or renal disease. Therapeutic diet luncheons are offered to the medicine clerks as a practical learning experience. Students attend lectures on enteral and parenteral nutrition and undergo a tasting session of defined formula diets. Other medicine lectures consider the metabolic, addictive, and nutritional aspects of alcoholism. Additional nutritional information is offered in clerkships in pediatrics and obstetrics-gynecology. A handbook of enteral and parenteral nutrition is being prepared jointly by the Nutrition Committee of the Talmadge Hospital. Other instructional input is planned for clerks in psychiatry and neurology.

2. Emory University School of Medicine

In their first 2 years, students at Emory University School of Medicine are offered an interdepartmental course in cellular biology and biochemistry. Biochemical regulation is discussed and includes principles of nutrition. Coordination provides a basic introduction to functional processes of organs and organ systems in man relevant to nutrition. A clinical nutrition course is offered in the second year. Practical aspects of nutrition prescribing, customs, attitudes, nutritional status evaluation, and behavioral modification are taught. Students are introduced to dieticians, taught how an interdisciplinary team works to solve problems in clinical nutrition. The areas covered include dental nutrition, consumerism, anthropology of nutrition, diabetes, obesity, and parenteral nutrition. In a 9-week period, medical students are required to evaluate and apply this dietary information on themselves, by taking their own dietary history, utilizing anthropometric measurements and, assessing their clinical nutritional status. In a tasting luncheon, students choose foods from a buffet. They make home visits with dietetic interns to apply their newly-acquired information to solve nutritional problems. During the core clerkships in medicine, pediatrics, surgery, and gynecology-obstetrics, clinical problems in applied nutrition are included. Seminars on nutrition are offered to students and faculty with invited guests speaking on such topics as hospital malnutrition, lactose intolerance, nutrition and alcoholism, and hyperlipidemia.

B. Elective

1. Medical College of Georgia

The Medical College of Georgia conducts an elective course in interdisciplinary clinical nutrition education for medical students. The medical student works as a member of a team involving physician's assistants, and dental, nursing, and nutrition students and sees patients in the Nutrition Clinic, Lipid Clinic, and hospital. This 4-week elective course is repeated nine times per year.

When the medical students successfully complete the elective course, they are qualified to perform a multitude of tasks that will enhance their performance as physicians. First, they are able to complete a nutritional assessment. This includes taking a nutritional and diet history, performing a detailed physical examination, collecting anthropometric measurements, ordering and interpreting appropriate laboratory studies, arriving at a nutritional diagnosis (including categorizing the patient's nutritional status), formulating a problem list, and developing an investigative plan. Second, the students are able to formulate and apply a plan of treatment to correct deficiencies, imbalances, or excesses. This nutritional intervention usually results in an improvement of the patient's health without impairment, such as a reduction in blood pressure in the hypertensive patient or weight loss in the obese patient. Third, the students are able to instruct their patients about behavior modification techniques necessary to sustain and/or improve their health. Patients with hyperlipidemia, for example, are instructed to apply a simple cholesterol-fat-calorie index to select appropriate foods for controlling their medical problem, or hypertensive patients are taught to select foods with appropriate salt content to achieve the sodium intake prescribed by the nutrition-wise medical student.

Medical students who complete this course demonstrate an ability to work cooperatively within the interdisciplinary team and evidence an understanding of the value of the contributions of the various team members. They apply team resources to the diagnosis and treatment of patients with nutrition-related disorders.

A faculty team consisting of a physician, nutritionist, and nurse serves as preceptor and role model for the student team. This team provides a variety of clinical services, including daily consultations in the hospital and/or clinic, weekly consultation rounds, the Lipid Clinic, and the Nutrition Clinic. These

faculty responsibilities provide patient care activities of an appropriate variety and quality to promote student learning in the program.

The educational aspects of the nutrition program are continually evaluated and monitored by an evaluation specialist. A skillfully designed evaluation plan utilizes pre and post tests, attitudinal surveys, and course critiques to judge progress. The plan evaluates the program participants, program objectives, instructional program, evaluation design, measurement instruments, and data analysis and decision making. Changes and improvements have been made in this elective course based on these evaluation data. The course is supported in part by a grant from the Bureau of Health Manpower, Department of Health and Human Services (DHHS — formerly DHEW).

2. Emory University School of Medicine

Longitudinal follow-up of graduates and faculty to monitor progress in nutrition and to determine the success of interdisciplinary projects should stimulate enormous interest in the area of applied nutrition. As a result of projects such as the interdisciplinary model at Emory, it is anticipated other medical schools will develop similar programs.

In order to develop more effective health practitioners in the area of nutrition assessment and intervention, the Schools of Medicine, Dentistry, Allied Health (Physician's Assistants and Dietetics), and Nursing have received a grant award from the Division of Allied Health Professions, DHHS, to expand and improve educationally applied nutrition in the curricula of these various programs. The goals of the current project are to provide students in these programs with basic appreciation, knowledge, and experience that will prepare them to apply nutritional knowledge in the promotion of health, the prevention of disease, and the amelioration of illness. An interdisciplinary nutrition program was needed in order to facilitate an atmosphere of shared communication and interaction among these various health professionals to promote proper nutritional patient care. It is anticipated that out of this interdisciplinary project, educational models, instructional materials, and improved teaching techniques will be developed which can be disseminated among institutions interested in applied clinical nutrition.

As part of the interdisciplinary educational project in applied nutrition, four seminars on nutrition were offered this spring for students and faculty in the various health disciplines. Outstanding speakers presented topics of interest in the field of nutrition as they apply to clinical practice.

As a result of this interdisciplinary applied nutrition project, it is hoped that the approach to teaching that will be developed at Emory will replace the current, more traditional methods of teaching medical students. During the project, the emphasis has been placed on interdisciplinary action which is a process in evolution. Faculty in the project will attempt to follow medical students and other health professionals throughout the training process and into practice in order to evaluate whether the outcomes are different under this teaching method than from the more traditional approaches to nutrition education.

Post-Graduate Nutrition Education

Medical College of Georgia Noon Conferences for house officers in medicine, also attended by students and faculty, provide monthly review of selected patients to illustrate topics which include: nutritional assessment, total parenteral nutrition, the prudent diet, nutrition for the elderly, dietary management of hyperlipoproteinemias, diabetes mellitus, renal failure, the cancer patient, nutritional anemias, and short gut. Annually, Grand Rounds in medicine presents a visiting professor on a topic of clinical nutrition, usually related to atherosclerosis or nutrition support.

The bi-monthly newsletter, *Food for Thought,* provides six pages of nutrition information, including abstracts of the current literature, invited review articles, historic Georgia nutrition landmarks, a nutrition quiz, and announcements of continuing medical education programs in nutrition. It is distributed to medical students, faculty, and house officers.

Nutrition education of house officers is also accomplished by providing consultation in nutrition assessment and therapy as well as supervision and advice for patients requiring nutritional support by enteral or parenteral routes.

Continuing education in nutrition sponsored by the Medical College of Georgia with invited guest faculty includes an annual 1½ day course which has reviewed such topics as nutrition support; critical care and obesity; diet-induced disease — alcohol, cancer, trauma and sepsis. In addition, the MCG faculty lectures throughout the southeast, state and nation to hospital groups, county medical societies, professional societies, and other universities on such subjects as hyperlipoproteinemias, fad diets, and nutrition support.

This year there will be a general session on Nutrition at the annual meeting of the Medical Association of Georgia. The invited Calhoun Lecturer, George L. Blackburn, M.D., Ph.D., will speak on hospital malnutrition. Other speakers will discuss nutritional assessment and nutrition support followed by a panel discussion. The session was planned by the Nutrition Committee of the Medical Association of Georgia.

That standing committee has as its charge to evaluate current trends in nutrition. The members prepare short position statements in the *JMAG* on timely nutrition topics to disseminate information to practicing physicians in the state.

In summary, required nutrition education courses in the Schools of Medicine at Emory and the Medical College of Georgia are receiving increased emphasis in the curriculum. Both institutions are operating an interdisciplinary education program which provides greater opportunity for medical students to gain increased innovative experience in clinical nutrition.

Physician education is being augmented through medical school conferences, grand rounds, and major continuing education conferences. As the importance of nutrition education becomes increasingly better understood, additional opportunities will continue to become available for medical students, residents and physicians.

Serving the General Insurance needs of
the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

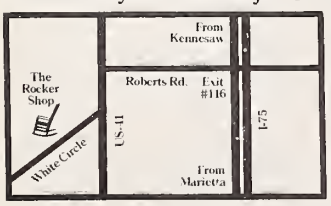
ROCKING THE NATION FOR OVER 100 YEARS...THE ONE AND ONLY BRUMBY ROCKER, ONLY AT THE ROCKER SHOP.

Few things have withstood the test of time as the Brumby Rocker. From it's early southern heritage, to today's White House, the Brumby has established a reputation as the world's finest handcrafted rocker. The moment production begins, to the moment we sell it to you, the Brumby is treated with the finest skill and care. The same skill and care used over 100 years ago when Brumbys were first made in 1875.

A Brumby Rocker is an investment in a future family heirloom. In fine homes throughout the country it has become a part of the family, rocking generations of children and a source of relaxation for all.

What gives the Brumby this enduring popularity? It begins with fine grained, solid oak which is half air dried and half kiln dried for natural expansion and contraction which helps prevent warping or bending. "Blue Tie" cane from Singapore is hand woven on both sides of the seat and back for comfortable cushioning and beauty from every angle. The steam bent back posts are curved to naturally cradle your back. The extra wide runners are designed with a slight rear arch to give an even rock and help prevent tipping. The man-size arms, with the original Brumby seal, let you rest your elbows comfortably. All are hand-sanded to a warm finish that accentuates the fine grained wood.

Good things are hard to find, but always well worth the search. If the Rocker Shop is a little out of your way, we'll gladly ship your Brumby Rocker anywhere. Major credit cards accepted.



The Rocker Shop of Marietta, Georgia

1421 White Circle, N.W. • P.O. Box 12
Marietta, Georgia 30061 • (404) 427-2618



The authors describe the varying needs of persons in different maturation phases, from the infant to the elderly, pointing up common barriers that undermine their health.

Potential Barriers to Good Nutrition

DONNA R. WATSON, M.S., R.D., SANDRA S. MOSSBROOK, M.D., and MARTHA JANE JOHNSON, M.S., R.N., *Atlanta**

Introduction

THE EXISTENCE of a plentiful and varied food supply in a society does not insure nutritional well-being for all of its members. The normal maturational process from infancy to adulthood certainly affects dietary intake and nutritional status, as does socioeconomic status and psychological attitudes. Some potential barriers to good nutrition will be discussed in the following article from the viewpoint of a nutritionist, a nurse, and a physician.

Infancy

At the very beginning of the independent life cycle, the nutritional status of children is of paramount importance. Infants are growing more rapidly than at any other time in their lives, usually tripling their birth weight in the first year. Thus, any deficiency in providing essential nutrients rapidly becomes evident. The sooner a practitioner recognizes a potential difficulty with infant feeding, the easier and more beneficial is the plan for the desired improvements.

Nature has provided a built-in mechanism of optimal infant nutrition in the breast-feeding mother. However, many pressures in current lifestyles interfere with this. Increasing numbers of working women whose infants are placed in day care centers or neighborhood homes find breast feeding an impossible logistical task. Unfamiliarity with nursing, brought about by the common use of infant formulas for the past two generations, has created a dearth of informal advice-givers to the nursing mother with practical questions. The medical community is as unable as the lay community to provide answers, further giving the non-verbal message that "bottles are easier." The breast is seen as only a sexual object by many people, and the idea of a baby suckling is viewed by many as obscene. Finally, nursing mothers are often advised not to take medicines (including birth control pills), smoke, drink alcohol, or eat spicy foods for fear of disturbing the infant's metabolism or gastrointestinal tract. Many women today are not willing to accept these limitations, and thus choose prepared formula instead. Unfortunately, the prepared formula, although very close chemically to human milk, can never contain the antibodies, the satiety mechanism, and the as yet unknown materials so important for human babies not found in substitutes.

Other barriers for optimal nutrition become evident as the infant is introduced to solid foods. In spite of the American Academy of Pediatrics' current recommendation to begin solid foods at 6 months of age, there are as many alternatives given to mothers as there are doctors and grandmothers to advise them. One doctor says rice cereal is okay at 2 weeks of age to help the baby sleep through the night. Another says, no rice cereal until the baby is drinking at least 28 ounces of milk per day. How is this quantitated for the nursing mother? One source says babies should eat vegetables first, as if fruits introduced first will cause the baby to get used to too much sweetness. Another says vegetables are too allergenic, and that fruits should be introduced first. One doctor gives vitamins to all infants; another gives this only to breast-fed babies; another gives no vitamins to any babies. Until there is more concrete data and thus more scientific backup for a consensus of opinion, doctors and grandmothers will both tend to give individual opinions, often based only on previous experiences, mostly with their own children! What is a new mother to believe in the midst of all this conflict between her major sources of information? Often she just gives her infant what she likes and thinks would taste good to the baby. Furthermore, with the current state of basic research, it is difficult to prove this well-meaning mother to be

* Ms. Watson is Associate Professor, Division of Allied Health Professions and Director, Interdisciplinary Education in Applied Nutrition at Emory University School of Medicine. Dr. Mossbrook is Assistant Professor, Course Director of Medical Student Nutrition, Dept of Preventive Medicine and Community Health at Emory, and Ms. Johnson is Assistant Professor, School of Nursing and Allied Health Professions at Emory. Address reprint requests to Ms. Watson at Interdisciplinary Education, Emory University School of Medicine, 2040 Ridgewood Dr., NE, Atlanta, GA 30322.

wrong, and we in medicine inadvertently provide a barrier of confusion that can hinder good nutrition.

Childhood

Physical and mental growth may be profoundly affected if good nutrition is not obtained for the growing child. Nutritional status may be most seriously affected by sociologic and psychologic factors. Since so many children today are not cared for by their natural parents, a new term has emerged to describe those who provide the home environment for the child, "care givers." The behaviors and lifestyles of the care givers are the most important factors in nutrition of the child. For example, in 1977, 18 percent of all children, compared to 12 percent in 1970, were living in families headed by single parents. Today, almost 50 percent of all children have mothers who work.[1]

By the age of 3 years, most children have learned the importance of food to their parents or care givers. Thus, they also learn that acceptance or rejection of food can be a good weapon for manipulation of those care givers. The child is now capable of specifically verbalizing wants and needs; if these do not correlate with the wants and needs of the care givers, battles for control develop. Three year olds have existed for months on bologna sandwiches, much to their parents' dismay and fears of malnutrition. The battle is not so much that the child loves bologna, but rather that he is exercising his budding independence in a very tangible way. Helping parents to understand this new ego growth is important.

It is difficult to identify all of the causes of either under-eating or over-eating problems in a child, because the factors may be as numerous as the number of persons and elements in the environment in which the child lives. The doctor, nurse, or nutritionist addressing the problems of poor food habits in a child must, indeed, take the time to find out what the most likely cause may be and help educate the parents (or care givers) so that they will be able to cope with their child's eating problems and help him/her establish better eating practices.

A child with numerous food allergies presents special problems to the average family, including changes in the spending limits, food selections, and the time for preparation of meals. There is, in addition, the very real potential of the diet's being very monotonous or inadvertently low in calories. If all the attention received by this child centers on his food intake, imagine the alterations in his perceptions of food and of his self image.

The child who overeats or who displays bizarre food selections (i.e. crayons, hair) may be sending us warning signals of a much more severe problem than just his nutrition. Educating parents and other care givers to both normal and abnormal responses to food will help in the establishment of good eating practices in their children.

Adolescence

Teenagers are a category unto themselves in potential nutritional problems. Peer pressure is a motivating force in all parts of an adolescent's life, and food intake is no exception. This can be to the good, as in the group's choosing milk instead of soft drinks to go along with a hamburger lunch or ordering pizza instead of apple pie for a snack. Also, however, peer pressure can provide a formidable barrier to good nutrition. Consider the great fascination with being thin. The body habitus of a teenager is never what he/she would like it to be, and so the solid, athletically built young woman may starve herself to fit into size 3 shorts and a halter top made for a tiny, late-blooming adolescent. Anorexia nervosa can be the extreme result.

Peer pressure to "build up your muscles and make the team" can make a boy take huge doses of vitamins daily, or try various diets of special liquids, "red meat," or strange food combinations. At best, these diets do not enhance nutritional status nor athletic prowess, and at their worst, they can be quite harmful to the developing teenager.

Once again, education of the teenagers themselves and the people who care for them is an important way to influence better nutritional habits.

Young and Middle Adulthood

The middle years are not a time that we usually associate with nutritional deficiencies. Adults, for the most part, are relatively healthy and productive both in career and family life. This age group is, however, becoming more and more the target of health practitioners' concern in terms of the disease prevention potential inherent in this maturational stage. Young and middle-aged adults are urged from all sides to engage in rigorous physical exercise, to reduce their body weight, to consume less sodium, sugar, and saturated fat. Certain groups advocate that adults of this age buy all manner of vitamin and mineral supplements, that they eat only specially grown, "pure" foods, and that they drink only water from a "pure" source.

Although concern for disease prevention is important, lack of nutrition education with which to combat the deluge of food and diet fads, or even lack of common household skills, may prove to be barriers that impair the nutritional status of this age group. There may be considerable difficulty in deciding among the ten to fifteen thousand items now found on grocery store shelves and making wise choices for one's best health. Furthermore, even persons in the lower income bracket very often choose to eat in the numerous fast food establishments that can be found in any neighborhood. Nutrition education is imperative, and nutrition education should include consumer skills related to making wise food choices.

The Aged

The number of older Americans is increasing substantially in our society and they now comprise about eleven percent of the population.[1] These twenty-four million persons are frequently at risk for nutritional problems caused by the physical, social, and emotional changes which accompany the aging process. These changes are potential barriers to optimal nutrition and many times lead to the nutritional deficiencies observed among the elderly. Although the following discussion will center on potential nutritional problems associated with aging, it should be remembered that many, many elderly persons cope well with the maturational process and maintain as optimal a nutritional status as they have in the past.

Chronic disease is frequently present in the elderly population, with eighty percent of our older people having one or more chronic conditions. The types of chronic disease seen in this group, such as diabetes, heart disease, or hypertension, have nutritional implications in that they usually require a change in eating habits. Although often cognizant of the medical rationale lying behind the need for a reduced sodium or calorie intake, the elderly often have difficulty adapting their eating habits to the new requirements.

In old people, it is often difficult to distinguish the effects of life-long food habits and current factors that may be influencing food selections and consumption. In some instances, there is an exaggeration of faulty food habits that have developed during earlier years, but in most cases malnutrition in the elderly is brought about by changes in economic circumstances and way of life. Elderly people especially at risk are the socially isolated (especially very old men living alone), those with low incomes, those in substandard living quarters, the recently bereaved, and those with mental disorders including depression. Fourteen percent of elderly Americans have incomes below the poverty level, compared to 12 percent in the population as a whole. Elderly blacks are affected to a much greater extent, with 36 percent of them living with below poverty incomes. Also, women in this age group have median incomes only about half that of men.[1] Therefore, the doctor, nurse, or nutritionist seeing geriatric patients must be oriented toward a psycho-social study of his/her patients as part of the medical examination and treatment.

In addition to chronic diseases, the normal physical changes associated with aging may present potential barriers to an optimal nutritional status. Obesity is a common problem among the elderly and may result from or be accentuated by the failure of an individual to adjust calorie intake to diminished energy expenditure. Also, people often overeat for the same reason others reject food — loneliness, hostility, or emotional disturbances.

Older persons seem to prefer foods that take little or no preparation, such as pre-packaged or easily consumed foods like crackers, pastries, and bagged snack food. Such foods will provide enough calories in many cases to maintain weight but will allow nutritional deficiencies to develop. Overconsumption of alcohol is another fairly common occurrence in the elderly. This can seriously affect the intake of nutritious foods as well as increase the risk of alcoholism.

The loss of teeth without replacement by properly fitting dentures can be an additional barrier to adequate nutrition. Age-related changes in the senses of smell and taste may decrease the interest in food or may increase the amount of salt and condiments used in an attempt to make food more palatable.

Almost every aged patient requires special considerations because of the changes in his/her physical condition which affect psychological reactions and behavior, or vice versa. Impairments in intellectual, adaptive, and visual-motor skills associated with the aging process are easily recognized. Some persons are better able than others to manage their loss of skills, the therapy for their illness, and regulate behavior in new situations. The combination of aging, illness, and psychological disruption make it difficult to determine whether the physical is secondary to the psychological, or vice versa, or whether they are of equal significance. The problems are usually so closely related that the health care practitioner must understand and deal with all of these factors in order to make his therapeutic work effective. Treating the elderly patient, therefore, becomes a complicated problem of combining medical and social services with a good understanding of the psychological needs of each individual to provide the best possible approach to care.

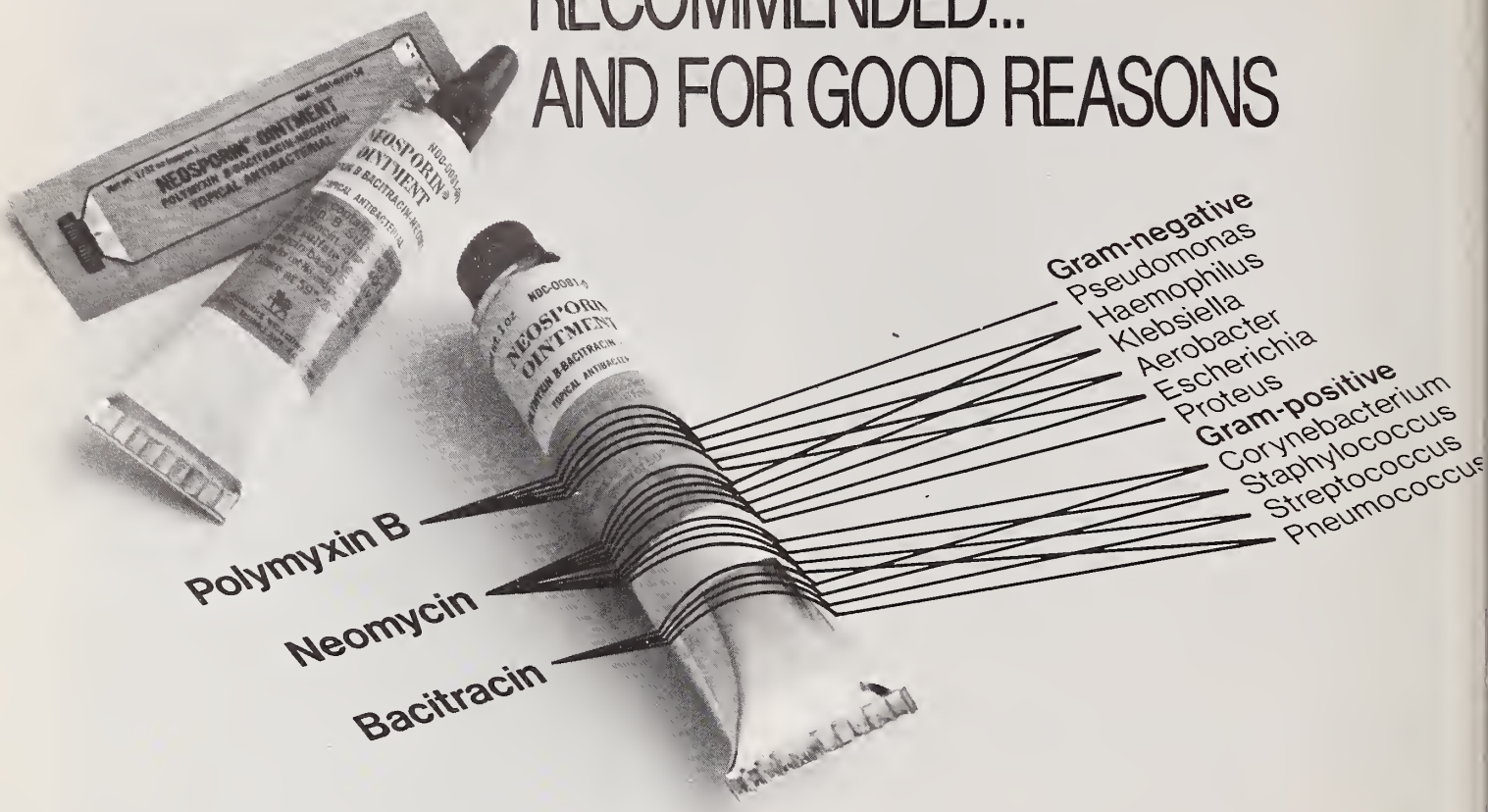
Summary

In spite of a plentiful food supply, many persons in our country do not have good nutrition. For many years, it has been accepted that specific disease conditions affect nutritional status. Now, other barriers to good nutrition are being identified. Psychologic attitudes and the social and economic milieu in which individuals find themselves influence food availability and selection. Also, responses to food and effects of food intake on nutritional status are largely determined by the current maturation level of an individual. Nutritionists, nurses, and doctors are becoming increasingly interested in helping remove the potential barriers to good nutrition, and the first step is to recognize them.

Reference

1. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. USDHEW (PHS). Pub. no. 79-55071, Washington, D.C., 1979.

IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
2. helps prevent topical infections, and treats those that have already started
3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically
5. you can recommend it in any of the three convenient package sizes: 1 oz tube, ½ oz tube, or the versatile, single-use foil packet



selected by NASA for the Apollo and Skylab missions

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Though much ado is made about the adverse effects of food additives, the author contends that the effects of poor nutrition are greater and warrant more public awareness.

Real and Perceived Issues on Food Safety — A Nutrition Perspective

ALLAN L. FORBES, M.D., *Washington, D.C.**

"O God, give us the serenity to accept what cannot be changed, courage to change what should be changed, and wisdom to distinguish the one from the other."

Prayer, 1934, Reinhold Neibuhr

As a graduate of a southern medical school (Medical College of Virginia, 1953), I have tried to put a number of thoughts on food safety together in perspective aimed at the real world of medical practice in that part of the country most familiar to me. I have to confess that, after nearly 20 years with the federal government in Washington, one of the most difficult tasks I know of is to search for and achieve that sense of perspective which reflects the true situation in the nation at large, rather than the situation as it may be perceived — often transiently yet forcefully — in the milieu of federal government at a given point in time. Furthermore, it is difficult to know if one has succeeded, but the attempt is always worth it.

I think much of the current concerns about food safety are out of perspective, both at the government level and with the general public. There tends to be an inverse relationship between concerns and resources expended, on the one hand, and public health significance on the other. I hasten to point out, however, that much of the imbalance is mandated by law. To make the point, one need only look at the enormous efforts, both public and private, that have been devoted over the past decade and more to attempts to prove or disprove harm to humans from consumption of cyclamates, saccharin, and nitrates. The answers are still illusive. At the neglected end of the spectrum, remarkably little effort has been devoted to the maintenance of the nutritional quality of our food supply as we go through a technologic revolution in the very nature of the food supply and our dietary patterns. There is equally little to education of both ourselves as physicians and the general public in the basic principles of effective nutrition. So much is now known about both deficiency disease and the adverse effects of excess food consumption that many of the answers are no longer illusive. Nutrient value should be the cornerstone of food safety.

To date, no one is known to have died or sustained serious injury as a result of consuming any approved food additive. This is a result of 75 years of effort to prevent injury since the passage of the original Pure Food and Drug Act in 1906. The system works. With the exception of the contribution of foods to lead poisoning of children, the number of victims of environmental contaminant poisoning from food is remarkably small, whether this be from heavy metals, pesticides, or other industrial chemicals. On the other hand, and as examples only, there are literally millions in this country with simple iron deficiency, and no physician need be reminded of the prevalence of obesity and its adverse effects on health. I do not mean for a moment to denigrate the efforts to understand and control the use of food additives to ensure safety and to undertake analagous efforts for environmental contaminants. I simply wish they were placed in better prospective as they relate to the overall matter of food safety.

At the outset, I made reference to the familiar quotation from Niebuhr about change, recognizing what one can and cannot do about it. It seems to me

* Dr. Forbes is Associate Director for Nutrition and Food Sciences for the Food and Drug Administration Bureau of Foods, Washington, D.C. 20204.

that Niebuhr's prayer is particularly applicable to the practicing physician and food safety issues. I cannot fathom how today's busy practicing physician can realistically play a determining role in events regarding the safety of food additives and control of contaminants. The issues are enmeshed in the realms of basic science and politics (in the broad sense of the word) and are controversial in the extreme. There is no universal agreement on how to test for safety in the experimental animal. There is much debate about whether one can or cannot generally extrapolate from animals to man when considering such factors as carcinogenesis, teratogenesis, mutagenesis, and, most recently, metabolic, immunologic, endocrinologic, and behavioral abnormalities. The applicability of retrospective epidemiologic studies is also argued, e.g. as to whether or not saccharin causes bladder carcinoma in man.

There is much debate about whether one can or cannot generally extrapolate from animals to man when considering such factors as carcinogenesis, teratogenesis, metagenesis, and, most recently, metabolic, immunologic, endocrinologic, and behavioral abnormalities.

The question of risk-benefit has now risen to the foreground in both scientific and political circles. One can legitimately ask: If we are having so much difficulty estimating "risk" — theoretically a scientifically quantifiable measurement — how can we hope to measure the far more subjective question of benefit? Occasionally — and I stress *occasionally* – the problem is simplified as risk-risk, for example, by the nitrate-nitrosamine issue in meat preservation, where the risk of botulinal toxin production from removal of the substance can theoretically be weighed against the risk of developing nitrosamine-induced neoplasms from continued use of the substance. It is rare indeed, however, when two such clearly definable medical events are identifiable. Artificial sweeteners are a case in point. Ultimately, risk may be definable, but the debate carries on as to whether or not such sweeteners are of significant value in obesity control or dietary management of the juvenile diabetic. It is fair to say that progress is being made in these areas. But an ultimate resolution is a complex, evolving, and often tortuous matter, based on gradual improvement of the biologic scientific base, political perceptions of importance, and, not infrequently, court decisions on matters of law. (This latter point is lucidly discussed in a recent editorial by Judge D. L. Bazelon in *Science,* 208: 16 May 1980). From the physician's point of view, a degree of serenity as to change would seem to be in order on these aspects of food safety.

On the other side of the food safety coin, however, there are many things the practicing physician can do, most of which focus on clinical nutrition. Philosophically, perhaps the most basic is to keep a watchful eye on two changing events: (1) The fact that the very nature of our food supply and our dietary patterns is undergoing radical change. Convenience foods, substitute foods, "fast foods," other away-from-home foods, and an incredible variety of nutrient supplements are a way of life for huge numbers of our population, from the infant to the young athlete to the senior citizen. This was simply not the case 20 years ago. (2) Even though obesity persists as a major public health problem, total food and caloric consumption has declined substantially, to the point that the average woman never exceeds intakes of 1900 calories per day at any age, the average man does not exceed 2800 calories, and among the 65+ year age groups, a man's intake averages 1700 calories per day and a woman 1250 calories. This in a function of increased sedentarism, coupled with the natural tendency to decrease caloric consumption to maintain caloric balance. The end result is that it is becoming increasingly difficult, particularly with the older sedentary individual, to meet or even reasonably approach recommended nutritional allowances, most of which are independent of caloric intake.

The federal government is beginning to pay more substantive attention to the provision of nutrition information to the public. The most visible example of this is nutrition labeling of packaged food under a voluntary program directed by the Food and Drug Administration (FDA) (the program becomes mandatory when nutrients are added to foods or nutrition claims are made about the food). Such labeling is currently found on about half of the processed and packaged food supply. Major steps are underway to revise and improve nutrition labeling, particularly to include declaration of sodium and potassium content on all nutrition labels, and to expand declaration of the content of cholesterol, fatty acids, and total sugars. The FDA believes that these steps will improve the ability of patients to adhere to fat and cholesterol modified diets and reduced sodium diets and to moderate consumption of potentially carcinogenic foods, particularly when physicians advise their patients to pay closer attention to food labels.

A second example is the recent (February 1980) publication of "Dietary Guidelines for Americans" by the Department of Health and Human Services (then, DHEW) and the Department of Agriculture. This 20-page brochure in lay language stresses seven major points: "eat a variety of foods; maintain ideal weight; avoid too much fat, saturated fat, and choles-

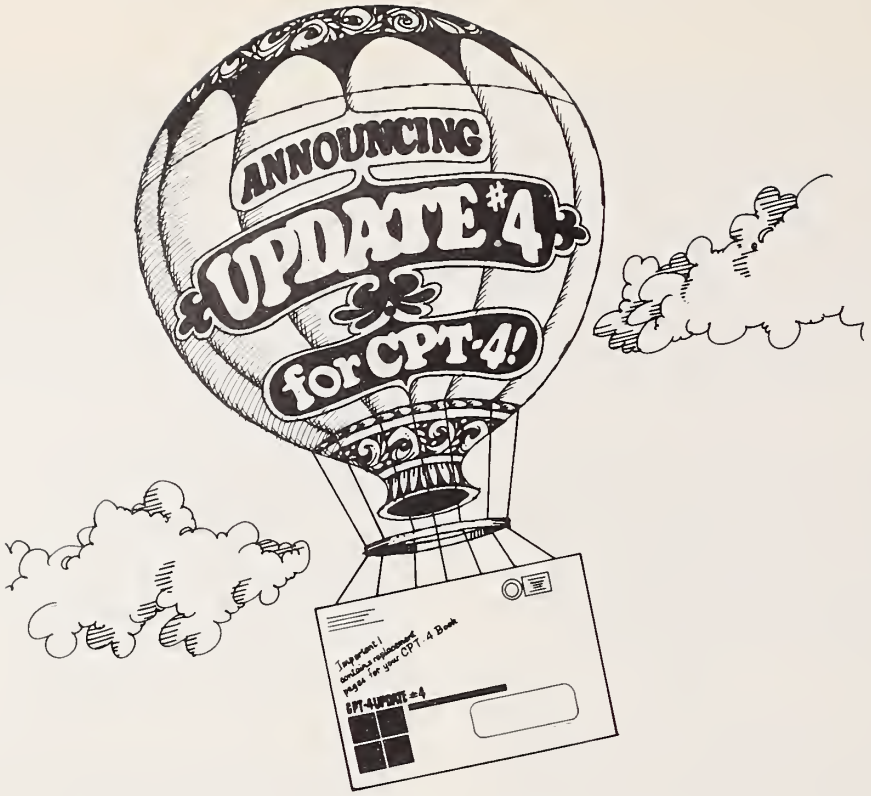
terol; eat foods with adequate starch and fiber; avoid too much sugar; avoid too much sodium; and, if you drink alcohol, do so in moderation." Copies are available from conventional local medical information sources including state and local medical societies, the Dietetic, Heart, and Diabetes Associations, public health departments, and FDA district and regional offices. Feedback to date indicates that the brochure indeed is a useful guide to many patients.

Since passage of the original Pure Food and Drug Act in 1906, there have been no reported deaths or cases of serious injury due to the consumption of any approved food additive.

The practice of clinical nutrition is coming into its own. As an Associate Editor of the *American Journal of Clinical Nutrition,* I have observed that the quality and quantity of original research and applied papers has greatly improved in recent years. It is exciting to see the advances being made in many areas, such as the increase in breast feeding and the better understanding of the composition and function of breast milk; trace mineral functions and human requirements; the application of total parenteral nutrition to nutritional management of the critically ill patient; better dietary management of patients with inborn errors of metabolism; advances in applications of food fortification to meet nutritional needs; the application of dietary neurotransmitters as therapy for several psychiatric disorders; the increased understanding of the relationship between diet and behavior; the continuing unraveling of dietary factors in the pathogenesis of both atherosclerotic and hypertensive cardiovascular disease; and so on. All of these advances ultimately improve our knowledge of food safety and the dietary pitfalls which exist for individual patients.

No synopsis of the nutritional aspects of food safety is complete without reference to the plethora of dietary supplements in the marketplace, and the propensity of vast numbers of individuals to consume them for prolonged periods. Nutritionally well-balanced supplements obviously are useful in certain clinical situations. Safety concerns arise from two factors. One is that the FDA no longer has the legal authority to regulate the composition and potency of vitamin and mineral supplements on the basis of modern knowledge of nutrient requirements but only on the basis of established toxicity. This is as a result of the 1976 Amendment to the Food, Drug, and Cosmetic Act, the so-called "Proxmire Amendment." The second factor is the paucity of knowledge of human nutrient toxicity for many nutrients. The toxicity of those that have been studied for decades is reasonably well understood, e.g., sodium, potassium, fluoride, Vitamin A, and Vitamin D. However, the long-term effects of excess consumption of some nutrients — even though under study for years — is still not clear, for example, the relationship of dietary iron to iron-storage disorders such as hemochromatosis. Most worrisome of all is the lack of knowledge of the toxicity of most of the trace minerals in the face of the popularity of consuming supplements of these nutrients contributing to intakes well in excess of needs. Among the popular items at present are supplements of selenium, zinc, chromium, and iodine (the latter as kelp). Even supplements of vanadium and molybdenum have begun to appear in the marketplace. Goodness knows where all this is going to lead, but it is indeed worrisome, and I am not convinced that current research and epidemiologic efforts are going to be able to keep pace with the course of public health events. Voices of moderation from physicians to their patients is much in order in this regard.

I urge you to think of nutrition when you think of food safety. In the final analysis, the nutritional quality of foods, or lack thereof, far outweighs the importance of food additives and contaminants in our society. As pointed out earlier, there is not a great deal the practicing physician can do to change the course of events relative to food additives and contaminants, but there is ample opportunity in the field of nutrition for the practitioner "to change what should be changed," and it is not difficult to "distinguish the one from the other."



That's what keeps CPT-4 the most current medical reporting system you can use!

The 4th Edition of *Physicians'* CURRENT PROCEDURAL TERMINOLOGY is the only coding system that provides new and revised terminology on a regular, automatic basis. This latest update, Summer 1980 marks the fourth update since CPT-4 was published in 1977.

The updates are on self-adhering pages that are affixed to the pages they replace in CPT-4. To activate the update mechanism, you simply return the postage-free card in the book.

CPT-4 is a uniform coding system to accurately designate medical, diagnostic, and surgical services in terms of a uniform language among physicians, patients, and third parties.

Shouldn't you be using the most current coding system available?

Order two—one for yourself, one for your medical records clerk.

For information about CPT-4 in computer tape format, write: Dept. of Applied Medical Systems, AMA, 535 N. Dearborn, Chicago, IL 60610.

Order Dept., OP-41
American Medical Association
P.O. Box 821
Monroe, Wisconsin 53566

SJ

Please send me_____ copy(ies) of *Physicians* Current Procedural Terminology, 4th Edition, OP-41. Price: $12 per copy. Enclosed is my check (payable to AMA) for $_____. Allow 4-5 weeks for delivery.

Name_____

Address_____

City/State/Zip _____

editorial
editorial
editorial

Nutrition — An Overview of This Special Issue

THE SUBJECT of nutrition has evolved into a political, professional, and emotional issue. This month's *Journal* focuses on nutrition and its importance to the practicing physician. Physicians have been accused of knowing virtually nothing about nutrition. This is obviously unfounded, when one looks at the basic sciences, especially biochemistry and physiology, where the fundamentals of nutrition are taught.

The article by **Feldman, Levy, and Curry** describes what medical students are being taught about nutrition at the Emory University School of Medicine and the Medical College of Georgia, pointing to the increased emphasis in postgraduate education on this subject.

Physiological, social, and economic factors, and their relationship to an adequate diet are discussed by **Watson, Mossbrook, and Johnson.** They discuss the widely varying nutritional needs of a person from infancy to old age. A main point in their article is the necessity for the recognition of barriers to good nutrition and how to remove them.

With the increased number of acutely and chronically ill patients who are often kept alive by sophisticated machinery, we are finding more need for nutritional support for these types of patients. This nutritional support is as important as respirators, hemodialysis machines, chemotherapy, and open heart surgery. **Horowitz, Smith, and Heymsfield** discuss the new developments in enteral and parenteral hyperalimentation that have reduced the morbidity and mortality of the severely traumatized patient.

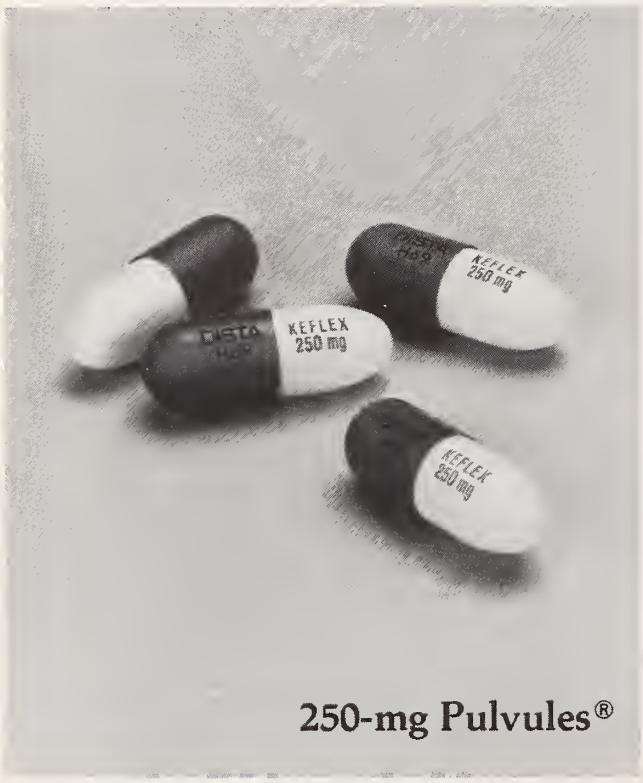
The two most common diseases related to inadequate nutrition are hypertension and obesity. **Tobian** discusses the relationship between salt intake and hypertension. He points out that the genetically susceptible individuals may be able to avoid hypertension by restricting salt intake in their earlier years. Modest dietary restriction enhances the antihypertensive effect of all antihypertensive medication. This is true even for those patients on thiazide and other diuretics in whom we at times forget to prescribe a low salt diet.

Physicians, a bit more so than the lay press and politicians, have increasingly become concerned over food safety, especially food additives. **Forbes'** article clearly points out that the nutritional quality of foods is far more significant than the presence of food additives and contaminants. Says Forbes, "No one is known to have died or sustained injury as a result of consumption of any approved food additive."

In future issues of the *Journal,* MAG's Nutrition Committee will contribute various articles concerning diet and disease. The subjects will include minerals and trace elements, vitamins, iron, hyperlipidemia, food fadism, diabetes, and gout. The MAG Scientific Assembly to be held in Atlanta in November will have a section on nutrition, with a panel of nationally known experts speaking on hospital malnutrition, nutritional assessment, and nutritional support. The Abner Calhoun Lecture for this year will also be on nutrition.

Judson G. Black, M.D.
Chairman, MAG Nutrition Committee

easy to take



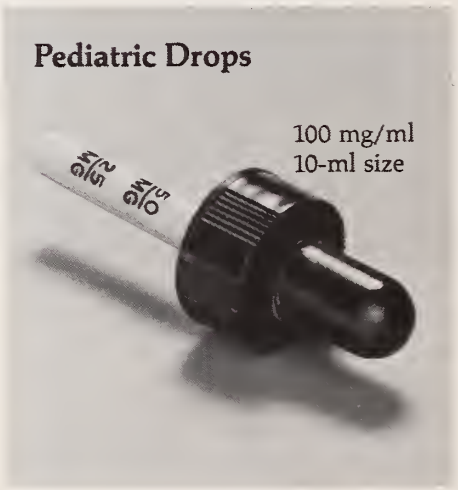
250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes



Pediatric Drops

100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

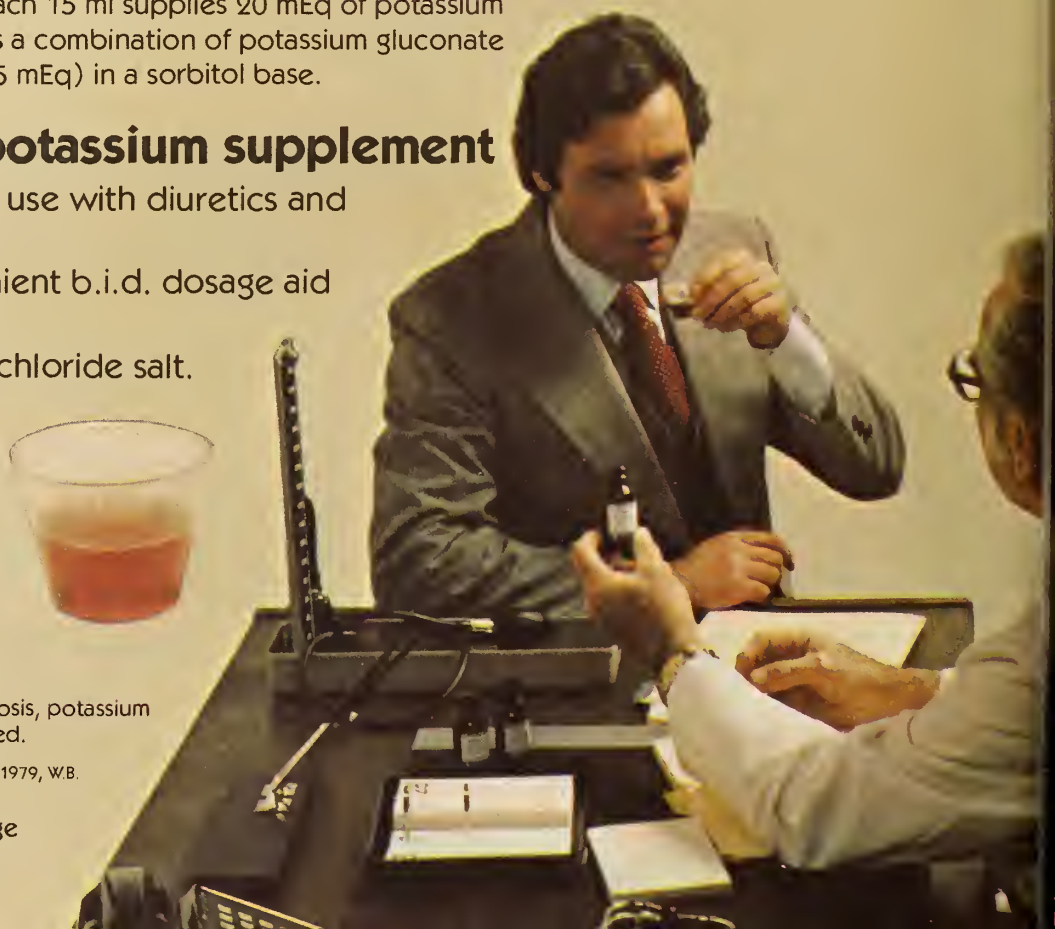
TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.





Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8—5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10—20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) or TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-0015-1

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001 5-80 Printed in U.S.A

NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

First Class Permit No. 1563, Shreveport, LA.

Postage will be paid by addressee

BOOTS PHARMACEUTICALS, INC.

Department 0
6540 Line Avenue
Shreveport, LA. 71106

BOOTS PHARMACEUTICALS INC.

Shreveport, Louisiana 71106

Pioneers in medicine for the fami

A properly utilized Keogh plan can double one's potential savings capacity up to the age of retirement.

Retirement Plans Available to Medical Practices

LARRY L. OTT, C.P.A., *Atlanta**

THE CHOICE of a retirement plan for your practice is limited by the form of organization under which you operate. Plans that are available to professional corporations are not available to proprietorships and partnerships, and vice versa. This article will focus on the most common plan available to proprietorships and partnerships.

Keogh Plans

The Keogh, or HR-10, plan provides the primary retirement medium for proprietorships and partnerships. As with all IRS-qualified retirement plans, there are three basic tax-related benefits to be derived from Keogh plans:

(1) Contributions to the plan by the proprietor or partner are deductible (within limits).
(2) Interest and investment income earned on the invested retirement funds accumulate tax-free until they are distributed.
(3) Benefits received under the plan are taxed when received, which is usually much later and hopefully at a time when the individual's income is lower and is taxed at lower effective rates.

A Keogh Example

The benefits of a Keogh plan can more easily be shown in the following example:

A 40-year-old doctor with an annual income of $100,000 wants to save $7,500 each year until retirement at age 65. If he is in a 50% tax bracket and earns 10% before taxes on his savings, his after tax savings will accumulate at a compound interest rate of 5% (50% of 10%). His total savings at the end of 25 years would be approximately $357,950 — $187,500 principal and $170,450 interest.

On the other hand, if the same annual $7,500 investment were put in a qualified Keogh plan earning 10% per annum, by age 65 the doctor could accumulate a total retirement savings of $737,600, approximately $379,650 more than in the previous example. This is due to the extra earning power of the plan's interest income that is not being taxed currently. Additional savings accrue from the tax deductibility of current contributions. In a 50% tax bracket, this would result in an annual tax savings of $3,750. Compounded at 5% over 25 years, another $178,980 could be accumulated after tax. Finally, when the benefits are taxed at retirement, the doctor's tax rate will probably be less than his tax rate at the peak of his career.

Other Factors To Be Considered

Other factors must be considered before adopting any qualified retirement plan. Common throughout qualified retirement plans, including Keogh plans, is the concept that a plan must not discriminate against lower paid employees in favor of more highly-paid persons. With respect to a Keogh plan, contributions for all eligible employees must be made on the same basis as for the self-employed owner. Generally, all full-time employees working 1,000 hours or more during the year and having at least 3 years of continuous service are eligible employees and must be covered. (Of course, the self-employed person must satisfy the same service requirements as common-law employees.) Thus, a self-employed doctor might

* Prepared at the request of the Medical Association of Georgia. Mr. Ott is a Supervisor in the Tax Department of Ernst & Whinney, Independent Certified Public Accountants to the Association, 3600 First National Bank Tower, Atlanta, GA 30303.

find that the cost of providing proportionate benefits for covered employees exceeds any tax savings that he could realize personally. On the other hand, many professionals find that despite the additional cost of covering eligible employees, this method of attracting and holding good employees is longer lasting and less expensive than bonuses or salary increases.

How Much Can You Deduct

Contributions by a self-employed individual under a Keogh plan may not exceed 15% of *earned income* or $7,500, whichever is less. Earned income includes professional fees and other compensation or fees received for personal service rendered in the trade or business with respect to which the plan is established. Additionally, the $7,500 and 15% limitations are figured only on the first $100,000 of earned income. Although a self-employed individual who is not an owner-employee is not limited as to the amount he may contribute to the plan, the amount he may deduct on his tax return cannot exceed the $7,500 or 15% limitation. Since a partner with a 10% or less interest in his partnership is considered not to be an owner-employee, the partnership may contribute more than $7,500 (up to 15% of his earned income). This allows that individual to accumulate greater earnings due to the effects of compound interest and the tax-free status of plan earnings. The partner's deduction on his tax return, however, is limited to $7,500.

Other Restrictions

Beware, however! There are numerous technical restrictions for Keogh plans in addition to the ones just mentioned. These include minimum and maximum distribution ages, various penalties for certain disallowed transactions, and allowable methods of funding. The plan may not begin paying retirement benefits to an owner-employee before he reaches age 59½ (except in cases of death or disability). Generally, in the case of death, the benefits must be distributed prior to the date of death of the surviving spouse. Payments of retirement benefits to owner-employees must commence no later than age 70½. Distributions to owner-employees prior to age 59½ (arising from other than death or disability) are subject to a 10% penalty tax in addition to being included in ordinary income. An additional 6% cumulative excise tax penalty is imposed for each year that excess contributions made on behalf of an owner-employee remain in the plan. Allowable methods of funding a Keogh plan include trusteed accounts with banks or insurance companies, U.S. Government bonds, and deferred annuity contracts.

Special Rules on Distribution

Special provisions to offset the effect of lump-sum distributions have also been created. If the participant receives a lump-sum distribution under certain circumstances, the portion attributable to pre-1974 service is treated as long-term capital gains, and the portion attributable to post-1973 service is availed of a beneficial 10-year-forward averaging method of tax computation. The requirements for favorable treatment are very specific, and the Code and Regulations should be followed explicitly.

Another Alternative

The Keogh plan may not be a viable alternative either because of the cost of covering other employees or because the self-employed individual may anticipate incorporating his business in the near future, which would qualify for a more favorable retirement plan. As an alternative, the professional may elect to establish an Individual Retirement Account (IRA) for himself only. Unfortunately, IRA contributions are limited to a maximum of $1,500 ($1,750 if the spouse is also covered).

In a future issue, the pros and cons of corporate plans will be discussed, along with possible planning considerations for professionals.

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
***21* Years' Service**

TALK IS CHEAP

in the *Journal*'s Classifieds

Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The ***Journal*'s Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.

Psychiatric Institute of Atlanta

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

WANTED:
Physicians who prefer medicine to paperwork.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect, where in almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime, where you work without worrying whether the patient can pay or you will be paid, and where you prescribe, not the least care, nor the most defensive care, but the best care.

If that is what you want, join the physicians who have joined the Army. Army Medicine is the perfect setting for the dedicated physician. Army Medicine provides wide-ranging opportunities for the student, the resident, and the practicing physician alike.

Army Medicine offers fully accredited residencies in virtually every specialty. Army residents generally receive higher compensation and greater responsibility than do their civilian counterparts and score higher on specialty examinations.

Army Medicine offers an attractive alternative to civilian practice. As an Army Officer, you receive substantial compensation, extensive annual paid vacation, a remarkable retirement plan, and the freedom to practice without endless insurance forms, malpractice premiums, and cash flow worries.

Army Medicine: The practice that's practically all medicine.

WRITE OR CALL COLLECT:

GEORGIA (Except Augusta Area)

MAJ. Dennis J. Leahy, MSC
HQ, U. S. Army Forces Command
Fort McPherson, GA 30330
(404) 752-2308

AUGUSTA, GEORGIA AREA

CPT. Edward R. Miller, MSC
Dwight David Eisenhower
Army Medical Center
Fort Gordon, GA 30905
(404) 791-6092

An Equal Opportunity Employer

Investment Via Limited Partnership: Limited Deductions/Limited Liability/Limited Control

WILLIAM J. ARMSTRONG, *Atlanta**

EDITOR'S NOTE: This article is the first of two installments describing the use of limited partnerships as a vehicle for investment. This installment examines in general terms the reasons for adopting the limited partnership format, as opposed to that of the standard or "Sub-Chapter S" corporation or general partnership, and also looks at the benefits accruing from the initial investment in a limited partnership. The second installment, which will appear in next month's issue, describes the methods of depreciating the property, both real and personal, in which the limited partnership invests and the requirements for "recapturing" that depreciation, and also offers some tips to the limited partner on how to retain limited liability while exercising some control over important matters.

RECENTLY, while on duty in the emergency room, you and a colleague were discussing his investment with a professional real estate syndicator. This syndicator has formed a "limited partnership" and has contracted to purchase a sizable apartment project in the name of the partnership. He has been selling interests in the partnership for $8,000.00 each, and fortunately, there are still a few interests left.

During the discussion, your colleague explained that under the federal income tax laws, an owner can depreciate apartment buildings for tax purposes on a straight or an accelerated basis, even though the buildings may actually be appreciating. Thus, each partner will be able to deduct from his own income his proportionate share of the tax losses resulting from the depreciation; the more interests purchased by each partner, the greater his share of the tax losses. Moreover, rental revenue will be more than enough to cover operating expenses and provide a quarterly cash distribution to each of the partners, income which will be sheltered by the depreciation. If that isn't enough, the syndicator plans to hold the apartment project for 3 or 4 years, just long enough for the effect of depreciation to drop, and to sell the project, with the gain from such sale to be taxed at the long-term capital gains rate.

In the discussion, however, your colleague kept referring to the syndicator as the "general" partner and said that you would be a "limited" partner. Later, when reviewing the investment literature, you note a form of a proposed "limited partnership" agreement. The agreement contains the following language which gives you some concern about the security of your money should you choose to invest:

> "The limited partners shall not have any right or power to take part in any way in the control of the business of the partnership . . . "

What does it mean to be a "limited" partner? Limited in what sense? Why is the syndicator a "general" partner? Why, if you give this syndicator $8,000.00 for every interest you purchase, can't you have any control over the business of the

* Prepared at the request of the Medical Association of Georgia. Mr. Armstrong is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

partnership? Suppose you want the rental rates increased so that there are larger cash distributions or suppose you catch wind of an offer made to the general partner to sell the apartment project at what you consider to be a very favorable price? Can you cause the general partner to increase the rental rates or sell the project?

The Uniform Limited Partnership Act, as adopted in Georgia, is designed to provide a vehicle whereby a person could invest a certain sum with limited risk and not become involved in the day-to-day affairs of the venture.[1] In certain instances, the straight corporate form of investment may not be suitable because the corporate entity is a taxpayer, and the income would be taxed twice, once as income to the corporation and again as dividend income to the shareholder. A limited partnership, on the other hand, is only a reporting entity, and income and losses are passed through proportionately to the partners. A "Sub-chapter S" corporation, which avoids the double taxation problem, also may not be suitable because you are limited to 15 shareholders, and it is difficult to meet the "active business" test with an investment in real estate.[2] Finally, the traditional partnership form may not be suitable because each partner is personally liable for all of the debts and liabilities of the partnership, and this liability is not limited to the extent of a partner's investment.[3] Thus, investment in a general partnership might subject your home and other personal property to the claims of unsatisified creditors of the partnership should the venture fail. That leaves you with a limited partnership as the most viable investment entity.

Normally, a limited partnership will have one or two general partners who will operate the business of the partnership, in our example, run the apartment project on a day-to-day basis — collecting rent, dispossessing delinquent tenants and maintaining the premises. These general partners will have the full liability of a partner in a general partnership, as described above. Capital for the venture will be raised by selling limited partnership interests, usually with a fixed number of interests being offered at a fixed price per interest,[4] and by borrowing from various lending institutions.

So, what do you get for your $8,000.00? You will be able to participate in a larger investment than you could do on your own, and you will limit your exposure to loss to just the $8,000.00.[5]

To elaborate, a crucial factor in the success of this participation is your ability as a limited partner to increase your tax basis in your partnership interest by your pro rata share of any non-recourse borrowings made by the partnership, if the borrowed money is invested in real estate. Normally, a partner can only deduct losses (such as those generated by depreciation) to the extent he is "at-risk" in the venture.[6] In our example, that would be $8,000.00 (times the number of interests acquired), because under state law your liability as a limited partner is limited to the amount of your contribution. The general partner with his unlimited liability has the right to deduct losses without such a limit. However, if non-recourse borrowings are incurred by the partnership for real estate investment, federal tax law allows each limited partner to increase his basis in the partnership by his pro rata share of the non-recourse borrowings.[7] For example, if you purchase one interest out of the ten available interests for a contribution of $8,000.00, you have a 10% interest in the partnership with a basis in that interest of $8,000.00. Then, if the partnership acquires a parcel of improved real property by giving a non-recourse note in the principal amount of $120,000.00, your adjusted basis in your partnership interest will increase to $20,000 ($8,000.00 + 10% of $120,000.00). You will be able to deduct losses over the life of the partnership up to a total of $20,000.00, yet your investment is only $8,000.00. Therefore, the importance of an increased basis in the partnership can be seen because it determines the extent to which losses can be deducted.

Obviously, you hope that the apartment project will be operated in such a manner that you will recover your investment plus a return on your money. It is important here to make the distinction between distributions of "net cash flow" from the partnership, typically on a quarterly basis, and allocations of profit and loss of the

partnership, an annual determination. Ideally, the rental revenues from the project should be sufficient to service the debt, to pay the expenses of maintenance and operation, and to provide for "dividends" in the form of cash distributions to each partner in accordance with his interest in the partnership. At the same time, the project should be on a depreciation schedule that will generate an annual depreciation expense which will cause the project to show a loss. That is to say, but for the depreciation expense (an expense for which there is no cash outlay), the project would have shown a profit. Your investment, therefore, is returned to you in the form of cash distributions sheltered from income tax by the loss deduction and in the form of a reduced income tax bill as a result of the excess of the loss deduction over the cash distributions.

Notes

1. *Ga. Code Ann.* §75-401, *et seq.*
2. For the success of your colleague's venture, real estate investment is necessary to gain the advantages of depreciation and non-recourse borrowing, as you will see below.
3. *Ga. Code Ann.* §75-103.
4. Generally, a limited partner will receive distributions of cash and allocations of profit and loss in the same proportion as his contribution bears to the total contribution, unless the partnership agreement provides otherwise. For ease of discussion, I have assumed in this article that distributions and allocations are in proportion to each partner's contribution.
5. It is not uncommon for there to be provision in the limited partnership agreement for the general partner to call for additional capital contributions from the limited partners upon the happening of certain contingencies. You should watch out for a very unfavorable buy-back provision in the event that you elect not to meet the "call."
6. Internal Revenue Code of 1954 §465, as amended.
7. *Crane v. Commissioner,* 331 U.S. 1 (1947); Internal Revenue Code of 1954 §752, as amended; Treas. Reg. §1.752-1(c).



WHAT WILL WE HAVE TO IMPORT NEXT, COLLEGE GRADUATES?

Ever since World War I, most of the rest of the world has come to the United States for the latest in technology. Now there's a real danger that the pendulum is swinging the other way. We're importing know-how in many fields instead of exporting it.

Unfortunately this situation will get progressively worse. Unless we protect American colleges from inflation. For our colleges and universities supply most of the important basic research upon which technological progress is built.

So please give generously. If we keep the intellectual balance of trade in our favor the industrial balance most certainly will follow.

HELP PRESERVE AMERICAN KNOW-HOW.
GIVE TO THE COLLEGE OF YOUR CHOICE.

COUNCIL FOR FINANCIAL AID TO EDUCATION INC. 680 FIFTH AVENUE NEW YORK NY 10019 CEA Ad A PUBLIC SERVICE OF THIS MAGAZINE AND THE ADVERTISING COUNCIL

IRA, Keogh– enjoy today while you plan for tomorrow.

Fulton Federal's IRA is designed for you if you are self-employed or employed but not presently covered by a qualified retirement plan.

With IRA (Individual Retirement Account), you can plan for tomorrow by contributing as much as 15% of your compensation (or earned income if you are self-employed) not to surpass $1500 in any one year. IRA allows your savings plus interest to be compounded and tax deferred until retirement or age 59-1/2. Consequently, when you do begin withdrawing money, you will probably be in a lower tax bracket, thus your taxes will be less.

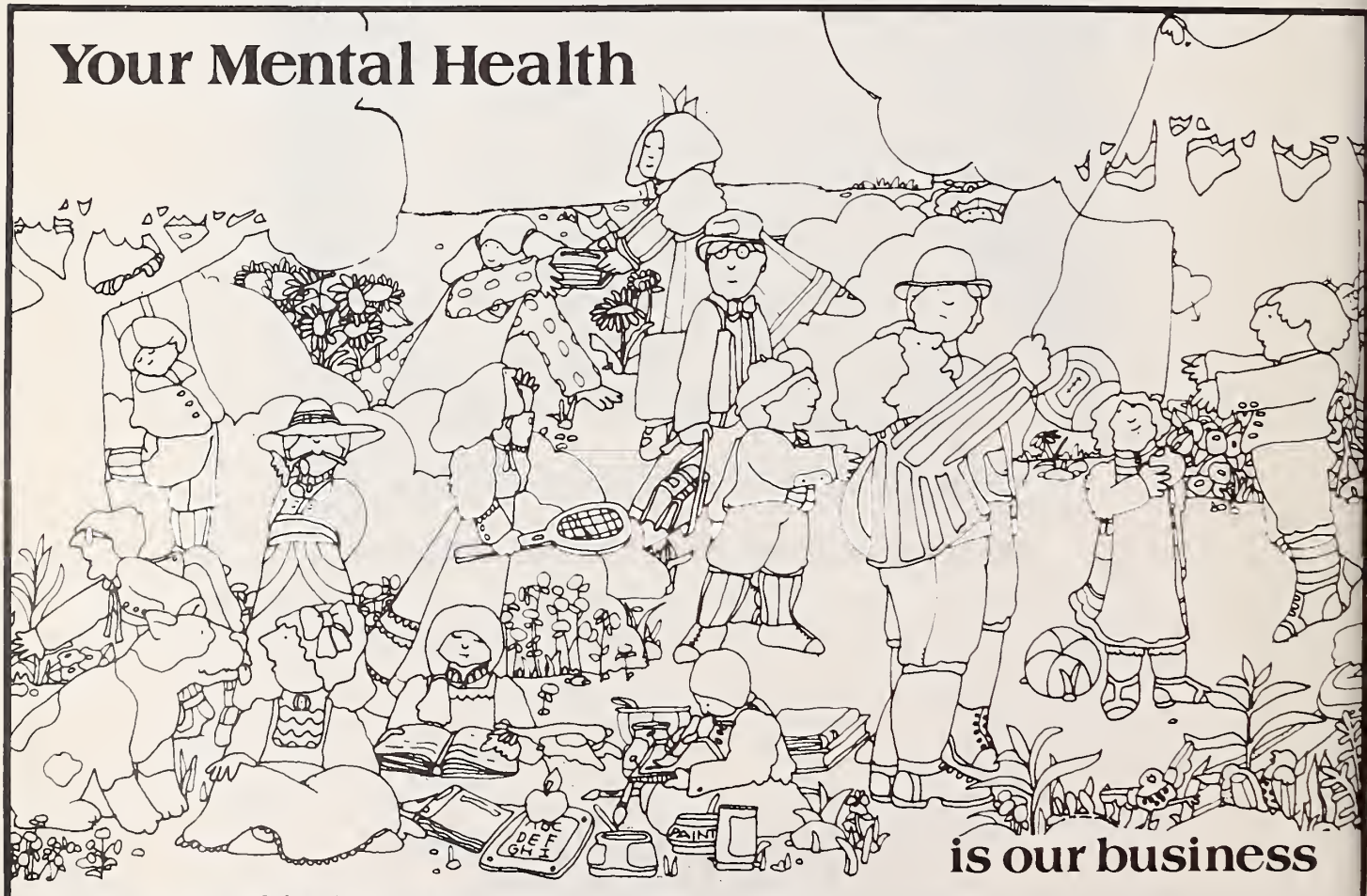
Keogh is designed for you if you are self-employed. With the Keogh retirement plan, your savings plus interest is also compounded and tax sheltered until time of withdrawal. You may deposit 15% of your earned income, not to exceed $7500 in one year.

For more information, call Fulton Federal's Retirement Plan Counselors at 586-7031. IRA and Keogh, two ways to plan for tomorrow.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta • P.O. Box 1077 • Atlanta, Georgia 30370

Your Mental Health



is our business

Brawner Psychiatric Institute • 3180 Atlanta St., S.E., Smyrna, GA 30080 Tel. 436-0081

Therapy of Hypertrophic Cardiomyopathy — New Directions

MARIO I. CANEDO, M.D., F.A.C.C.

HYPERTROPHIC CARDIOMYOPATHY is a primary disease of the cardiac muscle with a wide spectrum of anatomic, pathophysiologic, and clinical manifestations. The most characteristic anatomic feature is severe ventricular hypertrophy, usually more prominent at the level of the ventricular septum, while myocardial cellular disarray is found under the microscope.

Some patients exhibit left ventricular outflow tract gradients, the genesis of which is still debated. However, decreased ventricular filling secondary to severe hypertrophy appears to be a more important abnormality, since patients with and without gradients have a similar clinical course. The symptom complex is characterized by chest pain, exertional dyspnea, palpitations, presyncope, and syncope. However, it appears that the majority of patients are minimally symptomatic or asymptomatic. Unfortunately, sudden death is known to occur even in previously asymptomatic individuals. This represents the most common modality of demise and the greatest challenge in the management of the disease.

Investigators at the National Institutes of Health pioneered the surgical therapy of patients with hypertrophic "obstructive" cardiomyopathy. They postulated that resection of a slice of ventricular septum at the level of the outflow tract of the left ventricle should relieve obstruction and thus ameliorate symptoms. However, although most patients surviving the operation are symptomatically improved, the operative mortality is high. Moreover, sudden death continues to occur even in patients in whom surgery was documented to reduce or abolish obstruction. A multicenter study reported that the overall mortality rate following septal myotomy-myectomy was no better than that of natural course of the disease. Most investigators agree, therefore, that surgery should be reserved for severely symptomatic patients who failed to respond adequately to medical treatment and in whom the persistence of a gradient is documented by repeated cardiac catheterization.

The cornerstone of the medical management of patients with hypertrophic cardiomyopathy has been the use of beta blockers such as propranolol. Beta blockers have been shown to be effective in the improvement of angina by reducing intramural tension and heart rate. However, several reports indicate that propranolol appears to be less effective in the control of dyspnea and does not seem to prevent sudden death. Our experience at the Medical College of Georgia indicates that much larger doses of propranolol than are generally utilized are necessary to achieve sustained improvement. Doses above 320 mg a day of propranolol have been found to be required to achieve complete beta blockade. Propranolol exerts its

* Dr. Canedo is Associate Professor of Medicine, and Director, Cardiac Catheterization Laboratory, Medical College of Georgia, Augusta, GA 30901. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Stefadourous, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

beneficial effects in patients with hypertrophic cardiomyopathy by several mechanisms: negative inotropic effect reducing the hypercontractile state of the ventricles; reduction of heart rate and intramural tension, thus improving angina; as an antiarrhythmic agent; and finally, though not as yet adequately documented, by improving diastolic relaxation of the "muscle-bound" left ventricle.

Recently, several authors have reported a previously unsuspected high prevalence of arrhythmias in patients with hypertrophic cardiomyopathy including episodes of ventricular tachycardia, complete heart block, asystole and full blown cases of sick sinus syndrome. Our experience suggests that arrhythmias are probably responsible for presyncope and syncope rather than outflow obstruction as previously thought, since patients with hypertrophic nonobstructive cardiomyopathy are also well known to suffer these symptoms. Aggressive therapy of malignant arrhythmias has resulted in improvement of presyncope and syncope. More importantly, it appears that antiarrhythmic therapy, including the use of pacemakers, has reduced considerably the incidence of sudden death. Although the mechanism of arrhythmias is probably of a different nature, prevention of sudden death has also been reported by antiarrhythmic therapy in patients with congestive cardiomyopathy and is being actively investigated in patients with coronary artery disease.

More recently, verapamil, a calcium blocking agent, has been shown to decrease the left ventricular outflow tract gradient in patients with hypertrophic obstructive cardiomyopathy. Shortening of left ventricular isovolumic relaxation with improved ventricular filling has also been reported both in patients with hypertrophic obstructive and nonobstructive cardiomyopathy. Short term clinical trials have documented clinical improvement in these patients.

Thus, there seems to be new hope in the management of patients with hypertrophic cardiomyopathy with the use of propranolol in adequate doses and aggressive antiarrhythmic therapy. If the test of time confirms the value of verapamil, calcium antagonists are likely to open a new era in the therapy of the disease, particularly for patients who do not respond or cannot tolerate propranolol.

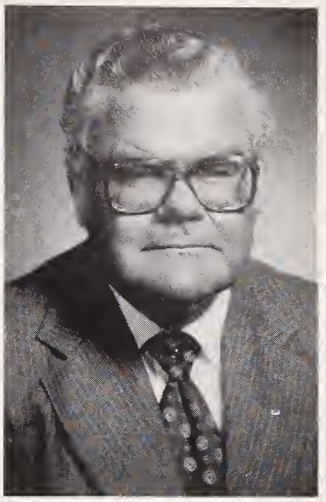
Bibliography

1. Maron BJ, Merrill WH, Freier PA, Kent KM, Epstein SE, Morrow AG. Long-term clinical course and symptomatic status of patients after operation for hypertrophic subaortic stenosis. Circulation 1978; 57: 1205-1213.
2. Frank MJ, Abdulla AM, Canedo MI, Saylors RE. Long-term medical management of hypertrophic obstructive cardiomyopathy. Am J Cardiol 1978; 42:993-1001.
3. Canedo MI, Frank MJ, Abdulla AM. Rhythm disturbances in hypertrophic cardiomyopathy: Prevalence, relation to symptoms and management. Am J Cardiol 1980; 45:848-855.
4. Hanrath P, Mathey DG, Kremer P, Sonntag F, Bleifeld W. Effect of verapamil on left ventricular isovolumic relaxation time and regional left ventricular filling in hypertrophic cardiomyopathy. Am J Cardiol 1980; 45:1258-1264.
5. Rosing DR, Kent KM, Maron BJ, Epstein SE. Verapamil therapy: A new approach to the pharmacologic treatment of hypertrophic cardiomyopathy. II. Effects on exercise capacity and symptomatic status. Circulation 1979; 60:1208-1213.

ERRATA: In the September *Journal* "Heart Page" on echocardiography, correct the abbreviation "ASA" in lines 3 and 4 of the last paragraph of p. 779 to read, "ASD."

In the article, "A Pilot Study of Early Ischemic Lesions in the Myocardium" on p. 766, the legend for Figure 1 should be under Figure 2 and that for Figure 2 should be under Figure 1.

president's letter



CME—A Vital Necessity

In preparing remarks for this letter, I was amazed at the magnitude of information available specifically referrable to our Association's activities and policy on continuing medical education.

It is documented and directed in Chapter I, Section I, Article (H) of our Bylaws that the Medical Association of Georgia will reinforce recognition of an ongoing, life-long need for continuing medical education in the art and science of medicine through participation in programs of continuing education.

There is no CME requirement for membership in MAG, but CME, both professional and public, is a top priority in our Association.

It must continue to be our goal to develop the best possible CME programs that will have significant impact on a physician's daily practice as he faces particular clinical problems.

MAG's Education Committee, so superbly chaired by Edwin Evans, M.D., Atlanta, strongly recommends the community hospital as the most cost-effective and convenient setting for promoting CME for the physician.

The goal of MAG is to obtain accreditation for every hospital in Georgia that sponsors CME and that has a medical staff of at least twenty (20) physicians.

Our state and local specialty societies provide regular in-depth continuing education which supplements the CME gained from personal study and in-hospital conferences.

MAG supports this form of CME in two ways: fourteen specialty societies have been accredited in their CME programs; and our annual fall Scientific Assembly provides a forum for the specialty societies to coordinate their various CME programs together at one location.

MAG's 1980 Scientific Assembly will be held at the Omni Hotel in Atlanta on November 21-23. The complete program for the 1980 Assembly was published in the August issue of the MAG *Journal*. The entire production will be outstanding. It deserves your complete and personal support.

MAG does not support the concept of CME as a mandatory requirement for re-registration of the license to practice medicine. Our Education Committee strongly believes that the individual physician's personal desire to maintain his or her knowledge and skills is the best and the truly acceptable motivation for CME.

MAG strongly supports voluntary achievement in CME as a major priority and has established a goal of having 100% of our membership qualify for the AMA's Physician Recognition Award by 1985.

I do not say that CME guarantees excellence in medicine. Neither do I think that one's ability to pass an examination has much to do with the ability to give good patient care.

But it is obligatory that none of us fails to do everything necessary to render top quality patient care.

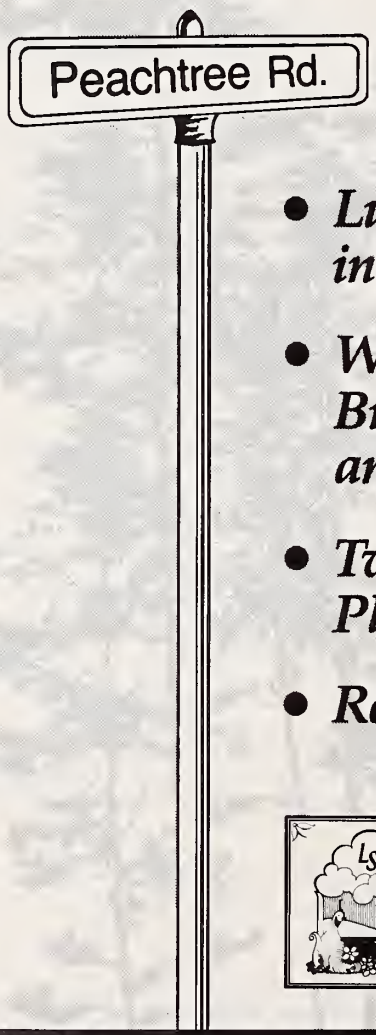
And that is where CME becomes positively vital.

Sincerely,

H. Hilt Hammett Jr., M.D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

Your Retirement Residence Will Soon Be On This Street



- *Luxurious accommodations in a new 23-story building*
- *Within one mile of the Brookhaven Country Club and the Standard Club*
- *Two minutes from Phipps Plaza and Lenox Square*
- *Refundable Entrance Fee*

Lenbrook Square

Write or Call: John Pettit or Jack Clark
Lenbrook Properties • 10th Floor — Lenox Towers
Dept. ME • 3390 Peachtree Road
Atlanta, GA 30326 • 404 / 233-3000

NEW MEMBERS

Ayres, Julian A., DeKalb—N-2—OPH
542 Church St., Decatur 30030

Bowen, Alan L., Floyd-Polk-Chattooga—N-2—ORS
15 Rockridge Cir., Rome 30161

Buntin, William H., Jr., Dougherty—ACT—AN
Phoebe Putney Hospital, Albany 31701

Dennis, Donald P., MAA—N-2—OTO/OS
3280 Howell Mill Rd., NW, Ste. 304, Atlanta 30327

Feagin, Steven J., MAA—I&R—IM
4165 Oakcrest Dr., Tucker 30084

Fodiman, Martin S., Worth—ACT—IM/GS
P.O. Box 785, Sylvester 31791

Hirsh, Eugene H., MAA—N-2—IM/GE
1285 Peachtree St., NE, Ste. 121, Atlanta 30309

Liu, Joe C., Walker-Catoosa-Dade—ACT—PD
150 Gross Crescent, Ste. 210, Ft. Oglethorpe 30742

Lott, Dan A., Ware—I&R—OBG
700 Riverside Ave., Waycross 31501

Masroor, Mohannad A., Georgia Medical Society—ACT—IM/CD
100 E. Park Ave., Savannah 31401

Mays, Wallace D., Sumter—N-2—OBG
401 S. Lee St., Americus 31709

Myers, B. Rhett, Peach Belt—N-2—P
1017 N. Houston Rd., Warner Robins 31093

Pratt, Frank G., Jr., Floyd-Polk-Chattooga—N-2—P
Harbin Clinic, Rome 30161

Pratt, Suzanne G., Floyd-Polk-Chattooga—ACT—OBG
909 S. Fifth Ave., Rome 30161

Shirley, Rudy M., Whitfield-Murray—N-2—OTO
1308 Memorial Dr., Dalton 30720

Starr, Trammel, III, Floyd-Polk-Chattooga—N-2—PUD
1825 Martha Berry Blvd., Rome 30161

Williams, Willis H., MAA—ACT—OS
Emory University Clinic, 1365 Clifton Rd., NE, Atlanta 30322

PERSONALS

First District

John Bell, Jr., M.D., of Dublin, was honored on his 70th birthday in an article in the *Macon Telegraph* commemorating his years of service to the people of the Laurens County area.

James Roshto, M.D., of Statesboro, has resigned as chief of staff of the Bulloch Memorial Hospital. **Charles Richardson, M.D.,** also of Statesboro, former chief of staff, has taken over the position.

David E. Tanner, M.D., Savannah, was elected for Fellowship in the American College of Radiology.

Second District

Gerald N. Kadis, M.D., a Thomasville neurosurgeon, was the guest speaker at the July meeting of the Cairo Rotary Club.

Third District

On July 1st, **James M. Eaton, Jr., M.D.,** associated with the PAPP Clinic in Newnan to practice urology.

Fifth District

Joseph Citron, M.D., recently moved his practice to Calhoun.

Sixth District

Patrice B. Sapp, M.D., a recent graduate of Howard University Medical School in Washington, D.C., opened her practice in Gray, Georgia. Dr. Sapp is an appointee of the National Health Service Corps.

Seventh District

The Harbin Clinic in Rome has added two physicians to its medical staff: **Alan L. Bowen, M.D.,** an orthopedic surgeon and **Trammell Starr, III, M.D.,** in pulmonary medicine.

Two hospitals in Cobb County have elected new officers. At Kennestone Hospital, **Emerson Cochran, M.D.,** of Marietta, was elected president; **W. Talbert Williams, M.D.,** of Smyrna, was elected vice president; and **Robert Stephens, M.D.,** of Marietta, secretary. **John Roberts, M.D.,** Austell, was elected president of Cobb General; **Ronald Rosen, M.D.,** Austell, was elected vice president; and **Sergio Pausa, M.D.,** Mableton, secretary.

Melvyn Fletcher, M.D., Marietta, has been named a Fellow of the American Academy of Pediatrics.

Ray Fowler, M.D., Douglas, recently assumed the directorship of the Parkway Regional Hospital emergency room.

Waco physician, **Jim L. Rodgers, M.D.,** was elected president of the Redmond Park Hospital Medical Staff.

Eighth District

Dan Abbott Lott, Jr., M.D., opened his medical practice September 2 in his native town, Waycross.

Tenth District

William B. Strong, M.D., Director of Pediatric Cardiology and a Charbonnier Professor of Pediatrics at the Medical College of Georgia, was the first speaker at the eighth annual Athletic Injuries Symposium. Dr. Strong spoke on the uniqueness of the child athlete. The event, sponsored by the Georgia Medical Society, was designed for coaches, athletic trainers, and physicians in the area. **Paul F. Jurgensen, M.D.,** of Savannah, chairman of MAG's Sport and Medicine Committee also addressed the group.

SOCIETIES

Charles D. Hollis, Jr., M.D., Chairman of MAG's *Ad Hoc* Committee on Professional Liability Self Insurance, spoke to the September meeting of the **Muscogee County Medical Society.** His topic was "Should MAG Self-Insure?" The Society also held a barbecue October 9 at the Green Island Country Club, welcoming physicians who had moved to Columbus during the past year.

DEATHS

James W. Reid

James W. Reid, M.D., 88, of Thomasville, died July 15. He had served the county for 60 years as a physician and in various civic capacities.

Dr. Reid received his M.D. degree from the University of Texas Medical School in Galveston. During World War I, he served as a lieutenant in the U.S. Army Medical Corps. After his discharge from the service, he opened his practice in Thomasville. He also taught the first class of nurses at Archbold Memorial Hospital.

Survivors include his wife and two daughters.

Robert M. Flowers

Robert M. Flowers, M.D., 54, died August 24. He had practiced in Columbus for over 22 years.

Dr. Flowers was born June 30, 1926, in Columbus. He was instrumental in changing the Trust Company of Columbus from a mortgage lending company to a bank.

He was a member of St. Paul United Methodist Church, the Muscogee County Medical Society, the Medical Association of Georgia, the American Medical Association, the American Academy of Pediatrics and the board of directors of Trust Company of Columbus. He was also a member of Kappa Alpha fraternity.

Survivors include his wife, three sons, two brothers, and a sister.

Fred Elliott Goldwasser

Fred Elliott Goldwasser, M.D., 68, a prominent Alma physician, died August 8.

Born in New York, Dr. Goldwasser graduated from the Columbia Medical School and New York University and served his internship at Morrisania Hospital also in New York.

He practiced in Alma for 41 years. Dr. Goldwasser was a member of the Waycross Hebrew Center, the Medical Association of Georgia, the American Medical Association, and the Ware County Medical Society. He served as chief of staff at the Bacon County Hospital and at Twin Oaks Nursing Home in Alma.

Survivors include his wife, a son, a daughter, a brother, two sisters, and two grandsons. Memorials may be sent to Waycross Hebrew Center.



ANNUAL NEGOTIATING SESSION BETWEEN THE MAG AND ST. PAUL. THE CONTINUING SAGA OF THE RISING RATES

On May 15, 1980, the Annual Negotiating Session was held between the MAG and the St. Paul Fire and Marine Insurance Company — our springtime ritual when "the Company" tells us what it will cost to run scared for the next year. You will recall that they suggested a mid-year increase in premiums for medical malpractice insurance coverage in December, 1979. We rejected this, and the Company reluctantly agreed to continue until the usual negotiating time. For years, a Partial Payment Plan has been considered, whereby one might break up the large yearly premium into several smaller installments. This was scheduled to begin on July 1, 1980.

With the present "claims made" approach to malpractice coverage, one has problems at the time of alteration of a practice pattern, such as with disability, retirement, or death. We are now buying a policy in which this "tail end coverage" comes free in the event of death or disability. In the event of retirement, one must make some other provision. The St. Paul has a prepaid annuity policy which can cover one's liability during his retirement years. The Company is studying the feasibility of providing this coverage without charge after a certain age (such as 65).

For the first time in our many years of negotiating with St. Paul, we were given a rather accurate and detailed accounting of "the reserves" which all insurance companies carry in these situations and which has been very carefully guarded through the years. The information given to us was clear and accurate. It also confirmed exactly what most of us had suspected all the time, namely that reserves are being kept at an unrealistically high level and would appear to account for unusually comfortable profits above those which we have ordinarily assumed the Company was seeking. When St. Paul saw a worsening malpractice climate in Georgia in the fall of 1979, these reserves were increased to a rather alarming amount. We were told that this was done because the "legal climate deteriorated, more cases and higher awards appeared." In this regard, it might be interesting to note that any award (loss) over $100,000 is not used in rate setting for an individual state but is rather incorporated into the nationwide rate-making structure. We were told that St. Paul will try every case in which it is the opinion of their lawyers that there is a better than 50 percent chance of winning the case. We talked about this matter of the Company reserves at great length. Our own actuary, who had been to St. Paul and studied their figures carefully the previous week, was of the opinion that the unusually high increase in the reserves in 1979 was not justified. He did agree that our deteriorating malpractice climate in 1979 clearly indicated that some increase in the reserves was appropriate, however.

We talked about the establishment of a "claim review committee" in Georgia which would function in an advisory capacity to St. Paul. This committee would attempt to help the Company evaluate the authenticity and severity of a case — the possibility, for instance, that it could be won or lost. This is being established now and should be of some help to the Company in the future from the standpoint of claim evaluation.

One might then question, why all the fuss about the reserve fund and why have we pushed them so hard to divulge some of the information relative to its size and productivity? An insurance company such as the St. Paul writing liability insurance has two sources of developing profit — one is that of underwriting profit (the amount of money left from your premium dollar after all expenses have been paid) and the other income from investment of the monies held. Some of that investment income might come from capital put in by the shareholders but a great deal of it comes from prudent investments of your premium dollars which, if held long enough at good investment rates, may well (and usually do) generate even more in profit dollars than does the actual premium excess itself. Therein, of course, lies our interest in knowing more of the matter of reserves and our interest in having the amount of the reserves at least realistic and hopefully accurate rather than unrealistically inflated. The higher the amount of the reserves and the longer they can be held for investment, the greater the profit generated therefrom. The sticky part of the matter comes in that when you talk with the insurance company concerning their profit, the only figures which you ever talk about are those relative to premium dollar income. One at no time is given any information as to what the reserve investment income might be. And so we got a real education on the matter of reserves. We confirmed our suspicions that things are not nearly so bad for the St. Paul as they would have us think, and we finally came to the conclusion that there is probably nothing we can do about the matter.

And yet there *is* hope. The MAG several months ago established a committee, with Charlie Hollis in Albany as the chairman, to study the feasibility of self insurance. We have, of course, studied this situation over several years and have usually come to the conclusion that even though our premiums are

high, they are better than we could generate by our own company. Owning our own company would, of course, give us better control over the claims and certainly would give us better control over the underwriting process — we could screen out those people who are responsible for the high awards and thus the high premiums. The obvious disadvantage would seem to be the inexperience that we have in this particular field and the fact that we would have to compete with professionals such as the St. Paul. It has been estimated that to establish our own insurance company (to self insure) would require a minimum $2,000 per doctor assessment across the board in the state of Georgia. If the company were to fail, we would all stand to lose that money and probably the whole apparatus would disintegrate. There would be nobody to pick up the pieces or to buy the company. At the time of organization and implementation of such a company, one would seem to have several options. In regards to prior liability, one could "assume prior acts" and thus, it is estimated, generate a premium that would be about the same as we pay St. Paul at the present time. Or, one might purchase "tail coverage" from St. Paul and begin by paying first year claims, again developing a premium which would be about the same as we are now paying. These are the questions and options our new committee is trying to answer.

How bad has the recent experience in Georgia been? In 1977, there was one award of $200,000. In 1978, there were five awards totalling $756,000. In 1979, there were five awards totalling $550,000, and one award (the case in Augusta) for $950,000 which is being appealed. In 1980, we have had three awards totalling $534,000. It was this type of statistical evidence that led the MAG actuary, after very careful study of all the St. Paul figures, to agree that the Company request for a 23 percent increase, beginning July 1, 1980, in the excess coverage portion of our policy was realistic and reasonable and yet to advise us that the requested 33 percent increase in the basic coverage was not reasonable. We are presently negotiating these matters but will most likely come out with an approved increase next year, averaging out somewhere around 27 percent. Do we have to accept it? The process seems to be that the Company comes to us and presents these matters with their figures and justification for the request for a rate increase. We can agree or disagree with them. They must next have these rate adjustments approved by the insurance commissioner of the state of Georgia. If we agree with them, then, of course, the insurance commissioner will very likely approve them. If we disagree with them, he might just approve them anyway or else we can carry the matter to a full hearing and stand to win or lose in that arena. It has been our present policy to negotiate with the Company — something which we have done successfully over the past few years — and attempt to arrive at what we all consider a fair and equitable adjustment of the rates.

At the end of each of these Negotiating Sessions with the St. Paul, I always seem to come away with the same questions. One involves the extent to which one can trust the data and the individuals from which it comes. We have always tried to build in some credibility, over and beyond blind trust, by sending our own actuary for a couple of days to St. Paul to study the Company's figures, ask the proper questions, and come back to us with an independent recommendation. We do this at some considerable expense to the MAG and yet feel that it is a justifiable one. My own impression is that the data we are given are accurate and reliable. Some of the judgements and decisions made by the Company from the data are certainly suspect and reflect a natural hedging to protect the integrity and the profit margin of the Company. It is in this area that most of our efforts would seem to be most profitably expended. The matter of reserves, their amount and the length of time which they are held, is obviously of concern and yet seems almost to be a private matter of the Company over which we have practically no control. If we are going to continue purchasing our medical malpractice insurance from a commercial carrier, such as St. Paul, then I would seriously doubt that we would be able to find a company more receptive to negotiating, more honest with the data, more interested in doing something about controlling the rise in premium. The statement "You are lucky to be able to buy it and to buy it at that premium," does carry a modicum of truth at the present time in the state of Georgia. The real question, however, is whether or not we would be better off — paying lower premiums and obtaining the same if not better protection by organizing our own insurance company. It is this latter question which is being so actively investigated at the present time and the answer to which we would hope to have available in the next 6-12 months.

It might be of interest to you to know how the "malpractice premium dollar" is spent. We have been given the following figures in regards to St. Paul — these are the estimates upon which the 1980 rate development figures were formulated.

Loss and loss expense (including legal costs)	
(22 percent of this is legal expense)	66.7%
Taxes and licenses	3.5%
Claim Department expenses	3.8%
Profit	5.0%
General expenses (salaries, etc.)	6.0%
Acquisition (marketing and advertising)	7.2%
Premium discount (returned to doctor)	7.8%

(Continued on p. 880)



WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℞

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

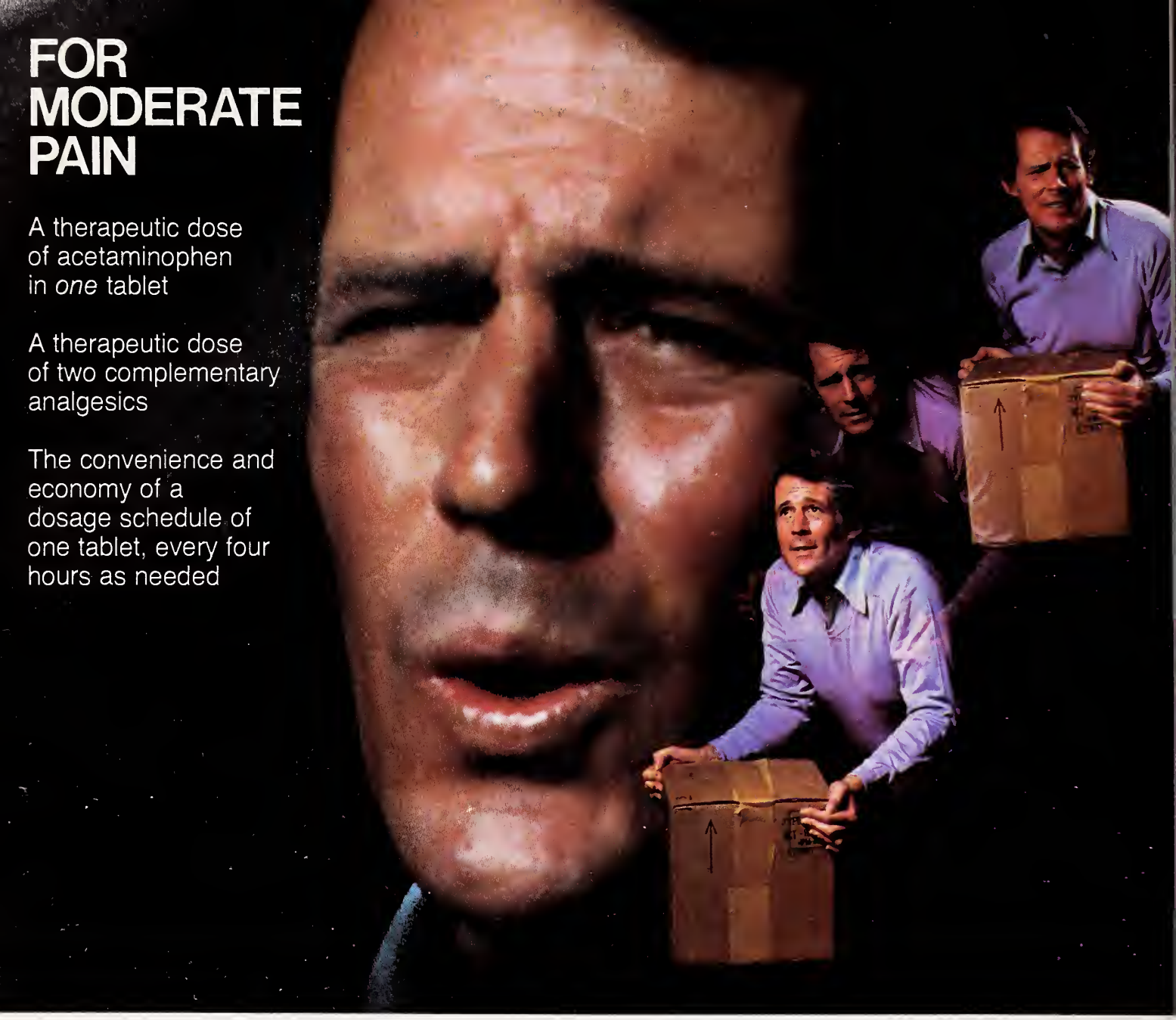
Wyeth Laboratories
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa. 19101

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award for July, 1980.*

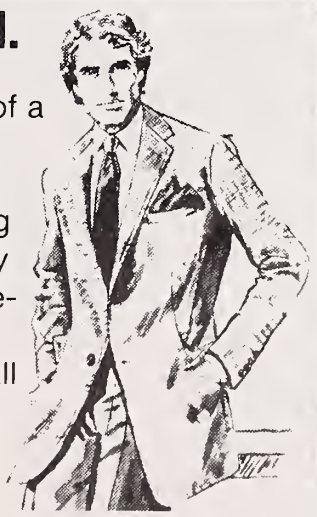
The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Ronald Gene Albright, Fort Benning
David Gordon Alfredson, Atlanta
Bruce Stuart Allen, Augusta
Stephen Clements Allen, Moultrie
Olav Henry Alvig, Cumming
Noah Samuel Bass, Atlanta
Victor C. Bell, Fort Gordon
Edward Walter Berg, Augusta
Dinker Bhole, Atlanta
Betty Sue Brooks, Augusta
Keith Robert Bucklen, Augusta
Alan Vladimir Burnstein, Atlanta
Diana D. Cardenas, Tucker
Larry Van Carson, Martinez
David Alan Causey, Atlanta
Bashir Ahmad Chaudhary, Augusta
Richard E. Chernecky, Stone Mountain
Nicholas C. Chubb, Martinez
Craig Brian Collier, Calhoun
Ervin Daniel De Loach, Savannah
Roger Wiley Deal, Columbus
Richard Erwin Dixon, Atlanta
Sally Faith Dorfman, Atlanta
Marshall Finley Eidex, Decatur
William Elsner, Columbus
Donald Paul Finnerty, Atlanta
William Carr Flanagan, Columbus
Fredric Charles Glass, Augusta
Robert Norment Harper, Augusta
Jimmie H. Harvey, Atlanta
William Causey Heard, St. Simons Island
Stephen Michael Herman, Savannah
Eugene H. Hirsch, Atlanta
Charles T. Ingram, Decatur
Henry Calvin Jackson, Augusta
William Kenneth Jann, Atlanta
Clarence Joe, Augusta
Ronald Ivan Kaplan, Atlanta
John Michael Kessinger, Macon
Harry Leroy Keyserling, Atlanta
Richard Wendell King, Atlanta
Robert Louis Lantieri, Atlanta
Kenneth Walter Lennox, Fort Gordon
David M. Martin, Atlanta
Walter William McBride, Marietta
Wallace Norman McLeod, Augusta
Eugene Neal McNatt, Dublin
James Paul Miller, Columbus
Kenneth Curt Molkner, Atlanta
John H. Moore, Atlanta
Havner Hurd Parish, Albany
Lawrence William Price, Villa Rici
David Benjamin Rausher, Decatur
George Whitney Reader, Decatur
John Canaday Reedy, Atlanta
Phillip Raymond Rogers, Atlanta
Stephen Daniel Rossner, Atlanta
Roger Michael Rossomondo, Carrollton
William Brandon Ruderman, Decatur
Leela Sharma, Savannah
Gregory Lawrence Simone, Marietta
Richard Aurelius Smith, Atlanta
Charles L. Spencer, Decatur
Suzie C. Tindall, Atlanta
William F. Tyler, Fort Gordon
Damon Joseph Underwood, Hawkinsville
Robert Michael Warren, Avondale Estates
James Quincy Whitaker, Warner Robins
Charles Herman White, Martinez
Robert Andrews Williams, Atlanta
John Seah-Hong Wong, Dunwoody
David Eugene Wukasch, Columbus

Guffey's classic look for fall.

Some things are timeless—the classic lines of a blazer, the conservative tailoring of a suit, practical and durable sweaters and well constructed shoes. At Guffey's discriminating gentlemen will always find clothing of quality and fine tailoring that result in a classic, timeless look. Come by today and view our selections—available in a rich spectrum of fall colors and patterns.



Guffey's
OF ATLANTA
Clothing for Men in Taste and Tradition

Peachtree Center
(Behind the Sculpture)
230 Peachtree Street, N.W. 404-522-0044

Tower Place
(At Piedmont Entrance)
3340 Peachtree Road, N.E. 404-231-0044
Ample Free Parking

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329

404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals


Have a Coke®
and a smile.
Coke® adds life.
registered trade-marks which identify the same product of The Coca-Cola Company.

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

TEGA-VERT CAPSULES

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

Each capsule contains:

Pentylenetetrazol (Metrazol)..... 50 mg.
Niacin (Nicotinic Acid)..... 50 mg.
Dimenhydrinate (Dramamine)..... 25 mg.

ADMINISTRATION & DOSAGE: One or two capsules three or four times daily before or after meals.

INDICATIONS: TEGA-VERT is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: TEGA-VERT should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

ORTEGA PRODUCTS ARE DESIGNED WITH THE FAMILY PHYSICIAN IN MIND

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

REG NO

THE DEVEREUX FOUNDATION

ARIZONA
CALIFORNIA
CONNECTICUT
GEORGIA

PENNSYLVANIA

MASSACHUSETTS
TEXAS
ARKANSAS

M

DATE

Age Pre-Adolescents Adolescents & Young Adults

By

HEDGES TREATMENT CENTER

Intensive psychiatric care for youths and young adults in transition, those who are not fully ready to utilize a conventional residential treatment approach but whose problems are not severe enough to warrant psychiatric hospital attention.

M.D.

By

Age 17-24

CAREER HOUSE

For intellectually bright high school graduating seniors, and post-high school youth with problems of underachievement and/or personal adjustment. Psychotherapy, academic and vocational counseling. Arrangements made for enrollment in local colleges and career schools.

M.D

By

Age Under 10

CENTER FOR AUTISTIC AND SCHIZOPHRENIC CHILDREN

A comprehensive, short-term, residential treatment program for severely disturbed children under ten years of age.

M.D

By

Age Adolescents and Adults

EDWARD L. FRENCH REHABILITATION CENTER

C. A. R. F. Approved

Residential and day programs. Comprehensive vocational evaluation, training and placement services. Opportunities for social adjustment training, work adjustment training, and sheltered employment.

M.D

. . . And many more separate day and residential treatment programs **prescriptively planned** for children and young adults with emotional and mental disabilities

Helena T. Devereux
Founder

Joseph B. Ferdinand
President

FOR INFORMATION AND LITERATURE:

National Director of Admissions is Charles J. Fowler, whose office is headquartered in Devon, Pa. 19333

PENNSYLVANIA Ellwood M. Smith, Admissions Director, Devon, Pa. 19333 or call 215 687-3000
CALIFORNIA Keith A. Seaton, Admissions Director, Box 1079 Santa Barbara 93102 or call 805 968-2525
TEXAS Betty H. Templin, Admissions Director, Box 2666, Victoria 77901 or call 512 575-8271
ARIZONA Richard A. Etter, Director, 6436 E. Sweetwater, Scottsdale 85254 or call 602 948-5857
GEORGIA Ralph L. Comerford, Director, 1980 Stanley Road, N. W., Kennesaw 30144 or call 404 427-0147
CONNECTICUT Theodore E. Enoch, Director, Sabbaday Lane, Washington 06793 or call 203 868-7377
MASSACHUSETTS Frederic A. Hervey, Director, Miles Road, Rutland 01543 or call 617 886-4746

. . . Carrying the Promise of Happy Tomorrows



THE DEVEREUX FOUNDATION

A NONPROFIT ORGANIZATION

All Devereux Branches Surveyed by the Joint Commission on Accreditation of Hospitals are Approved as Psychiatric Facilities for Children and Adolescents

Quit-Smoking Tips From the American Cancer Society

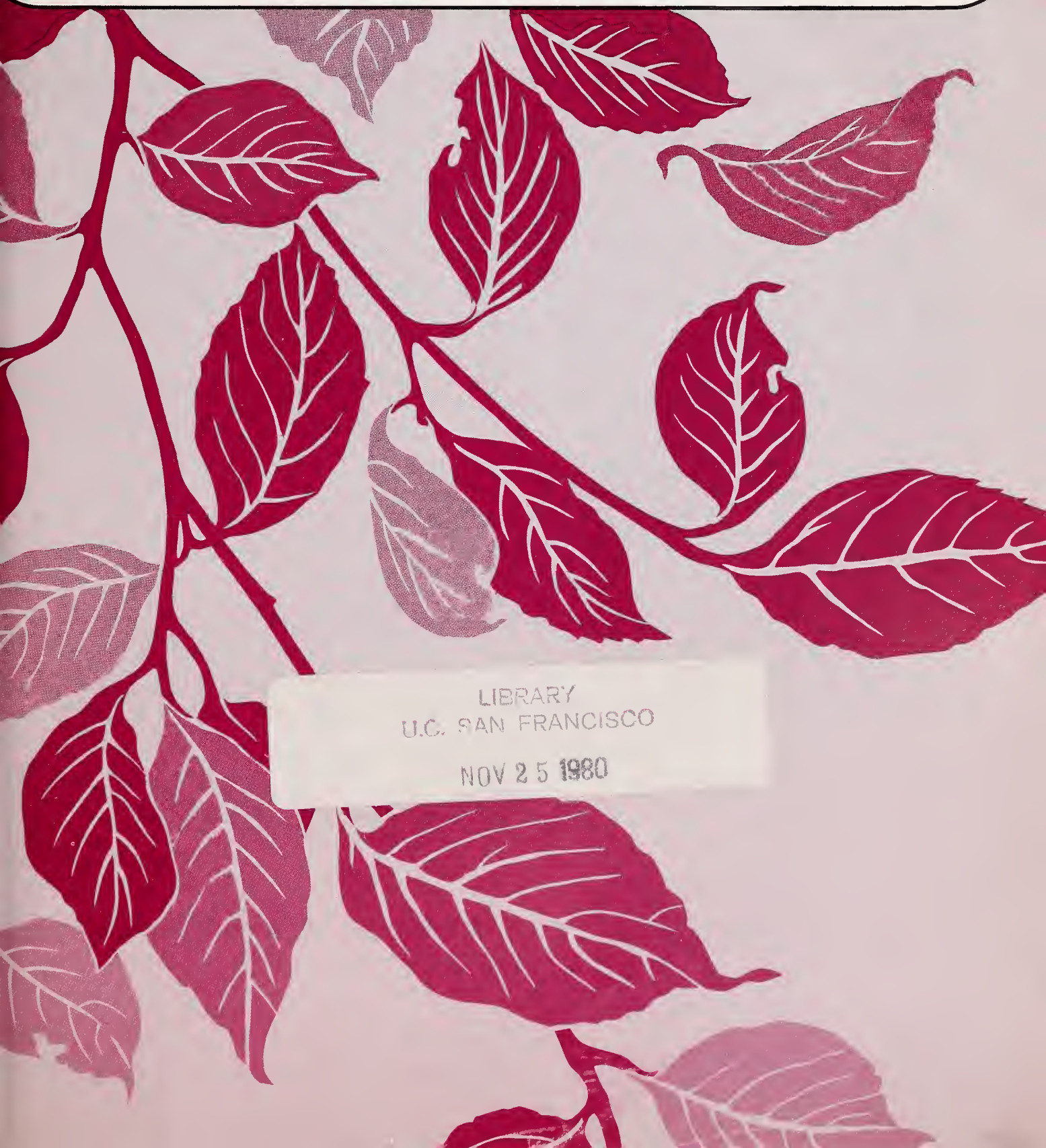
1. Before you quit smoking, try wrapping your cigarettes with a sheet of paper like a Christmas present. Every time you want a cigarette, unwrap the pack and write down what you are doing, how you feel and how important this cigarette is to you. Do this for two weeks and you'll have cut down as well as developed new insights into your smoking.
2. Make a list of what you like and dislike about smoking. Add to it and read it daily.
3. List the luxuries you have wanted or items you would like to purchase for a loved one. Next to each item write the cost. Then convert the cost to "packs of cigarettes". If you save the money each day from packs of cigarettes you would have bought, you will be able to purchase these items. Use a special "piggy" bank for saving your money, or start a "Christmas Club" account at your bank.
4. Bet someone that you can quit. Put cigarette money in a jar each morning and forfeit it if you smoke. You keep the money if you don't smoke by the end of the week. Try to extend this period to a month.
5. Plan a *date for stopping.* You might choose your vacation, New Year's Day, your birthday, a holiday, the birthday of your child, your anniversary. But, don't make the date so distant that you lose momentum.
6. If you smoke under stress at work, pick a date for stopping when you will be away from work.
7. Decide whether you are going to stop suddenly or gradually. If it is to be gradual, work out a tapering system so that you have intermediate goals on your way to an "I.Q." day.
8. Until you quit, make yourself a "smoking corner" far from anything interesting. If you like to smoke with others, always smoke alone. If you like to smoke alone, always smoke with others, preferably if they are nonsmokers. Never smoke while watching television.
9. Change your brand of cigarettes weekly so you are smoking a brand lower in tar and nicotine than the week before.
10. Keep your hands occupied. Try playing a musical instrument, knitting or working with hand puzzles.
11. Take a shower. It's hard to smoke in the shower.
12. Brush your teeth frequently to get rid of tobacco taste and stains.
13. If you have a sudden craving for a cigarette, take ten deep breaths, holding the last breath while you strike a match. Exhale slowly, blowing out the match. Pretend the match was a cigarette by crushing it out in an ashtray. Then immediately get busy on some work or activity.
14. Smoke only one-half a cigarette.
15. Shed your old habits. Seek new activities or perform old activities in new ways. Don't rely on the old ways of solving problems. Do things differently.
16. Visit places where you can't smoke such as libraries, buses, theaters, swimming pools, department stores.

QUICK-QUIT PLAN

1. List the reasons for and against smoking.
2. Change to a low tar, low nicotine brand.
3. Select a day to quit.
4. Chart your smoking habits for two weeks: how many cigarettes, when, which is the most and least important.
5. Each night, repeat at least ten times one of your reasons for not smoking.
6. Eliminate one cigarette from your routine: the most or least desired.
7. Quit on the day you selected. Keep busy: go to the movies, exercise, take long walks. Use substitutes, sip water, chew gum, eat raisins or carrots, chew a clove.

American Cancer Society, Inc.

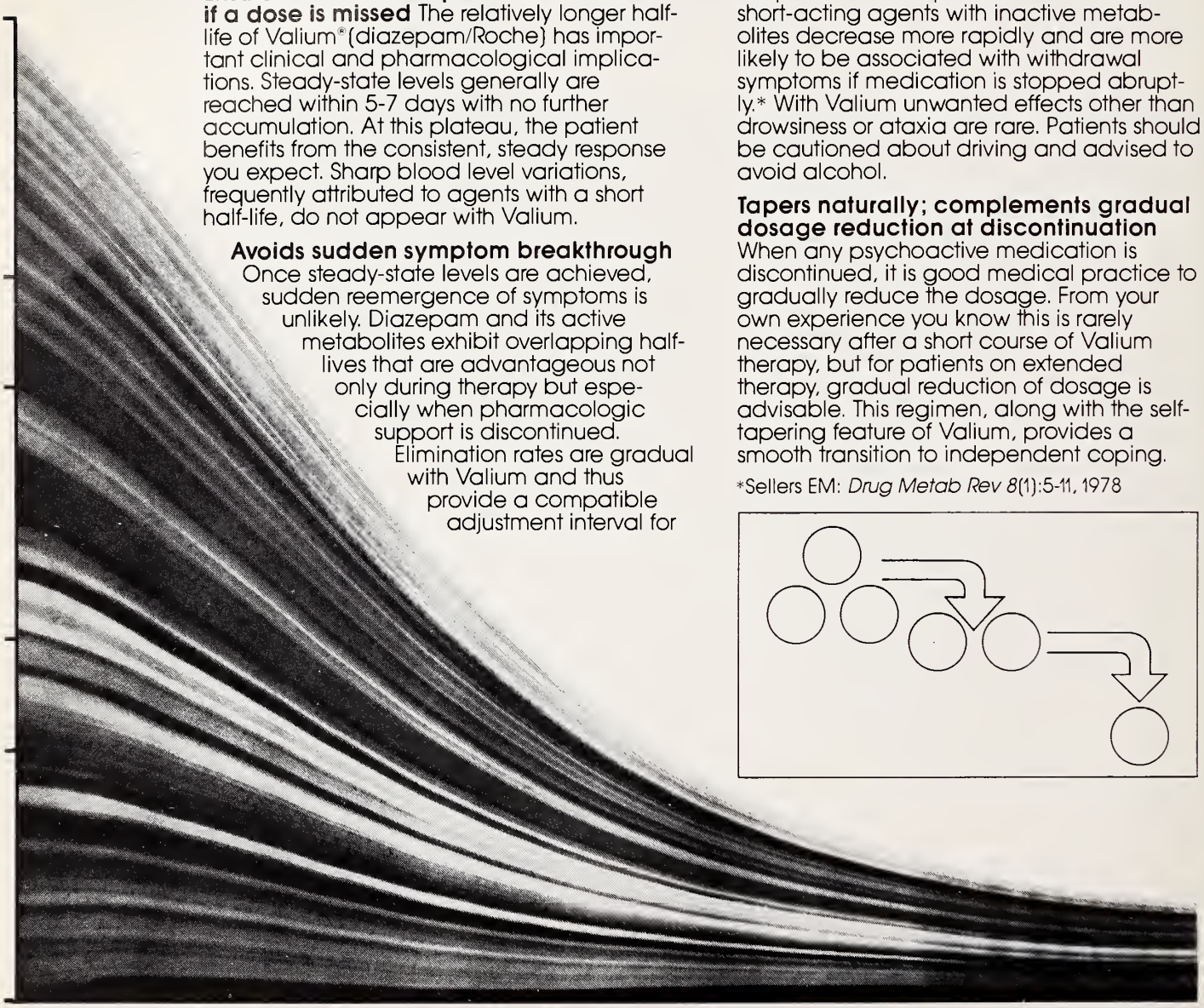
JOURNAL
of the medical association of
georgia
ISSN·0025·7028
NOVEMBER / 1980



LIBRARY
U.C. SAN FRANCISCO
NOV 25 1980

half-life

Just one built-in advantage



Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978

in the management of symptoms of anxiety

Valium®(IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

ROCHE®

Before prescribing, please see summary of product information on next page.

Valium®
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Office Equipment

Vacation Opportunities

Physicians Wanted

Recreational Equipment

Art 'n Antiques

Rental Property

If you want to buy an antique car . . . or sell a lucrative practice, or lease some prime office space or hire another associate, use the *Journal*'s **Classifieds** to get your message to thousands of physicians in the metro Atlanta area and around the state.

***Journal* Classifieds**
Reaches the Georgia Physician

FROM DIETARY COMPLAINTS



"Too Bland"



"Tasteless"



"No Variety"



"Hard To Cook"



"Only Cottage Cheese?"



"Dad Dull

TO COMPLIANCE



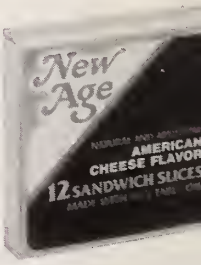
INTRODUCING New Age SANDWICH SLICES

- **90% less cholesterol**
- **75% less saturated fat**

Now, New Age—a cheese substitute made wi vegetable oil—provides the good taste of process cheese without its restrictively high cholesterol content.

New Age has 90% less cholesterol, 75% less saturated fat, yet provides all the protein, vitamins and minerals of process cheese... good news for all health-conscious patients!

AMERICAN
SWISS
SMOKEY
HOT PEPPER



New Age™ is consistent with the cholesterol-control, low-fat recommendations of the third edition of **The American Heart Association Cookbook.**

© 1980 Anderson, Clayton & Co. Complete nutritional information is available from Anderson Clayton Foods, P.O. Box 226165, Dallas, TX 75266.

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 11

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/ EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director
Joyce Butler, R.N., Assistant Executive Director
J. Tom Sawyer, Assistant Executive Director
Kenneth M. Williams, Director of Public and Professional Relations
Stephen Davis, Director of Education
Bert Franco, M.A., Assistant Director of Medical Practice
Gary Price, Assistant Director of Legislative Activities
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

901 Too Bad For You, Humpty Dumpty
William J. Morton, M.D.
917 Multiple Endocrine Neoplasia Involving Steroid Producing Glands
Kenneth Alonso, M.D.

SPECIAL ARTICLES

895 Specialty and Location of Recent Medical School Graduates in Georgia — Implications for Primary Care
Adam R. Jablonowski, M.P.A.
Philip W. Russell, M.S.H.S.
Sue A. Settles, B.S.H.S.
Bonnie J. Kay, Ph.D.
904 The Medical Career of Samuel H. Stout — Part I
Julia Emmons

EDITORIAL

919 Marijuana for Nausea and Vomiting in Cancer Patients
Stanley H. Winokur, M.D.
J. Jay Baker, M.D.
Julian L. Lokey, M.D.
Norma A. Price, M.D.

FEATURES

924 Heart Page/Hypertension: Morbidity, Treatment, and Compliance
Arthur J. Merrill, Jr., M.D.
935 Legal Page/Investment Via Limited Partnership: Limited Deductions, Limited Liability, Limited Control
William J. Armstrong

THE ASSOCIATION

888 Letter to the Editor
941 President's Letter/Legislation — A Continuing Involvement
H. Hilt Hammett, Jr., M.D.
943 New Members
943 Personals
943 Societies
943 Deaths
944 Physician's Recognition Award Recipients

INCIDENTAL INTELLIGENCE

888 Auxiliary Sponsors Workshops
888 AMA Advises No Increase in NHSC Till More Studies Completed
891 Medical Meeting Calendar

COVER

Would that the richness of color in the dogwood leaves at this season remind us of the richness of our country's heritage and make us thankful. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

Incidental Intelligence . . .

Auxiliary Sponsors Workshops

An A-MAG sponsored legislative workshop designed to familiarize Auxiliary members with the legislative process of state government and to involve members in working for responsible health legislation was held in Macon on September 22. Approximately 40 auxilians, representing county legislative chairmen, county presidents, and interested members from 12 counties, gathered for the all-day workshop, held in conjunction with workshops for county treasurers and county presidents-elect.

A panel of expert speakers included the Honorable Richard Greene, senator from the 26th District, who was opening speaker. Mr. Rusty Kidd, Associate Executive Director of MAG, addressed the group on, "How A Bill Becomes Law in Georgia." Dr. J. Roy Rowland, member of the House of Representatives and a member of MAG, spoke on current medical issues in Georgia and on those bills expected to be introduced in the 1981 Session. Others on the panel were Dr. Beverly Sanders who conducted a brief discussion of GaMPAC; and Mrs. Emmerich von Haam and Mrs. James Joiner, both members of the A-MAG Legislation Committee.

[Reported by Mrs. Thomas W. Marks (Mary Ann), Chairman, A-MAG Legislation Committee.]



Under the auspices of the Auxiliary to the MAG, (L-R) Mrs. Emmrich Von Haam (Julie), Mr. Rusty Kidd, Mrs. Milton B. Satcher (Ann), Georgia's State Senator Richard Greene, and Mrs. Thomas Marks (Mary Ann) headed up the Legislative/Treasurers workshops in Macon on September 22, 1980.

AMA Advises No Increase in NHSC Till More Studies Completed

The American Medical Association has told Congress the National Health Service Corps (NHSC) program should not become the primary means of financing medical education through federal scholarships. At the same time, the AMA supported the goals of the program in providing medical personnel to "truly underserved" areas.

Joseph Boyle, M.D., Vice Chairman of the AMA Board of Trustees, told the Senate Labor Subcommittee on Health that the AMA sees problems with the Corps in the designation of shortage areas and in the placement of corps personnel. "A significant step to alleviate these problems would be to allow input in the placement of Corps personnel from local medical societies," Dr. Boyle said.

"Such input could also have the advantage of increased cooperation between practitioners and work to increase the retention rate of corps personnel in the communities where they are placed."

Dr. Boyle said that as more studies are completed it will be easier to plot the future of the Corps. Until such studies are completed, there should be no increase in the number of NHSC scholarships, he added.

"For the Corps to be most effective, it must work as an adjunct to the physician in private practice," said Dr. Boyle. "Only through the proper allocation of Corps personnel will health manpower shortage areas be eliminated."

September's Editorial, "On Medical Ethics"— A Reader Objects

Dear Editor:

I strongly object to the guest editorial by F. Edward Payne, Jr., which appeared in the September issue of the *Journal*. I regard this as a very thinly disguised statement of position of the "Right to Life" group masquerading as a discussion of ethical responsibilities of physicians.

The fact that I am totally in favor of abortion on demand for any woman motivates my concern less than my feeling that this attempt to influence the thinking of physicians was disguised at best and at worst has no business appearing in the *Journal of the Medical Association of Georgia*. I do not feel I need another physician to tell me what my moral responsibilities are with regard to respect for human life any more than I need any other individuals in any other aspect of life to define for me my moral responsibilities as they see them.

Sincerely,
Donald W. Fellner, M.D.
Decatur

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

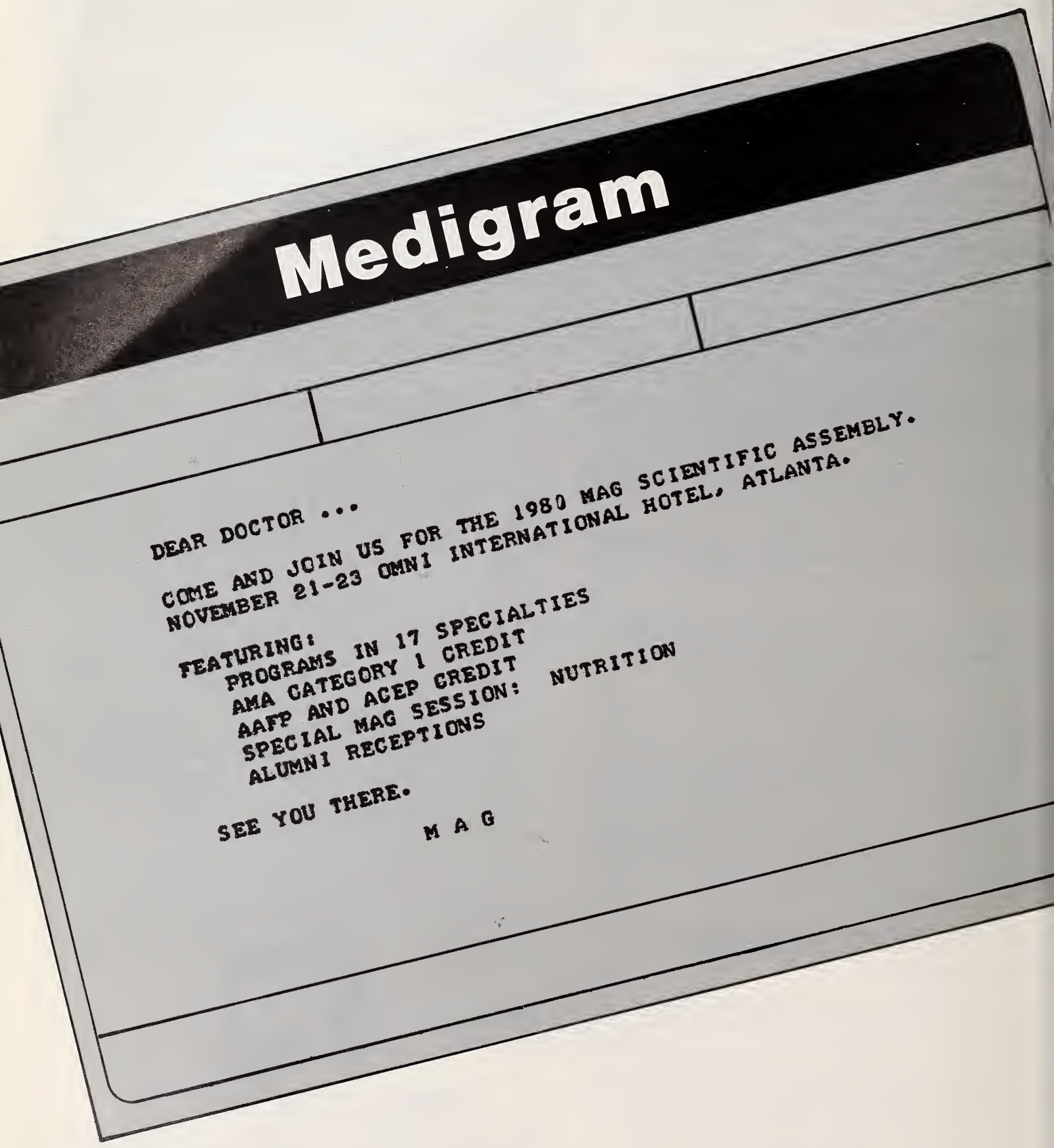
The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329
404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals


Medigram
DEAR DOCTOR ...
COME AND JOIN US FOR THE 1980 MAG SCIENTIFIC ASSEMBLY.
NOVEMBER 21-23 OMNI INTERNATIONAL HOTEL, ATLANTA.
FEATURING:
PROGRAMS IN 17 SPECIALTIES
AMA CATEGORY 1 CREDIT
AAFP AND ACEP CREDIT
SPECIAL MAG SESSION: NUTRITION
ALUMNI RECEPTIONS
SEE YOU THERE.
M A G

MEDICAL MEETING CALENDAR

NOVEMBER

21-23—*Atlanta;* **1980 MAG SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Sheila Carson, MAG, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535 or 800-282-0224 (toll-free in Georgia).

DECEMBER

1-2—*Atlanta;* **PEDIATRIC OPHTHALMOLOGY:** Contact: Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303.

3-5—*Lake Buena Vista, FL;* **LAPAROSCOPY TECHNIQUES AND THERAPEUTIC TECHNIQUES;** Contact: H. Worth Boyce, Jr., M.D., Univ. of So. Fla. Med. Ctr., 12901 N. 30th St., Tampa, FL 33612.

3-7—*Atlanta;* **5TH SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE;** Contact: Mary Galos, Peachford Hospital, 2151 Peachford Rd., Atlanta 30338. PH: 404/455-3200, ext. 550.

5-7—*Atlanta;* **CARDIAC ISCHEMIA AND ARRHYTHMIAS;** Category 1 credit; Contact: International Med. Ed. Corp., Div. of Postgraduate and CME, 64 Inverness Dr., East, Englewood, CO 80112. PH: 303/773-1144 or 800/525-8646.

12—*Atlanta;* **SIXTH ANNUAL INFECTIOUS DISEASES SEMINAR — 1980;** Category 1 credit; Contact: Dept. of Graduate and CME, Ga. Baptist Med. Ctr., 300 Boulevard, NE, Atlanta 30312. PH: 404/659-4211, ext. 2346.

12-13—*Jackson, MS;* **THIRD ANNUAL COURSE ON STRABISMUS;** Contact: Dr. Raul E. Valenzuela, Univ. of Mississippi Med. Ctr., 2500 N. State St., Jackson, MS 39216.

JANUARY 1981

22-24—*Charleston, SC;* **ALLIANCE FOR CONTINUING MEDICAL EDUCATION;** Contact: Lewis Miller, ACME, 322 Westport Ave., Norwalk, CT 06851. PH: 203/846-3441.

24-26—*Atlanta;* **22ND AMA NATIONAL CONFERENCE ON THE MEDICAL ASPECTS OF SPORTS;** Category 1 credit; Contact: AMA/Dept. of Meeting Services; 535 North Dearborn St., Chicago, IL 60610.

24-27—*Atlanta;* **AMA WINTER SCIENTIFIC MEETING;** Category 1 credit; Contact: Council on Continuing Physician Education, American Medical Association, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

24-31—*Snowmass, CO;* **FIFTH ANNUAL CONFERENCE ON PAIN: FACIAL AND NECK PAIN;** Category 1 credit; Contact: Ronald G. Havican, Ctr. for Rehab. Med., Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5507.

26-31—*Puerto Rico;* **PEDIATRICS IN REVIEW — 1981;** Contact: Judson Hawk, Jr., M.D., Scottish Rite Hospital for Crippled Children, 1001 Johnson Ferry Rd., Atlanta 30342.

FEBRUARY 1981

2-5—*Miami, FL;* **FLORIDA MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY;** Contact: Fla. Midwinter Seminar, Univ. of Miami Sch. of Med., 405 NE 144 St., Miami, FL 33161.

5-7—*Lexington, KY;* **FIBEROPTIC BRONCHOSCOPY;** Category 1 credit; Contact: Frank R. Lemon, M.D., Cont. Ed., College of Medicine, Univ. of Kentucky, Lexington, KY 40536. PH: 606/233-5161.

13-14—*Atlanta;* **TREATMENT OF PARANOID CONDITIONS;** Contact: Ga. Psychiatric Assn., 130 Sixth St., NW, Atlanta 30313.

15-20—*Lexington, KY;* **TWELFTH FAMILY MEDICINE REVIEW — SESSION I;** Category 1 credit; Contact: Frank R. Lemon, Cont. Ed., College of Medicine, Univ. of Kentucky, Lexington, KY 40536. PH: 606/233-5161.

16-20—*Savannah;* **CURRENT METHODS IN BLOOD BANKING AND IMMUNOHEMATOLOGY;** Contact: American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, IL 60612.

18-24—*Cancun, Mexico;* **ADVANCES IN CLINICAL MEDICINE;** Category 1 credit; Contact: Michael B. Kessler, M.D., Director, Physicians Medical Seminars, 970 Clemenstone Dr., Atlanta 30342. PH/ 404/971-8797.

23-25—*Atlanta;* **SOUTHEASTERN SURGICAL CONGRESS 49TH ANNUAL ASSEMBLY;** Contact: Southeastern Surgical Congress, 315 Boulevard, Ste. 500, Atlanta 30312.

MARCH 1981

2-6—*Chicago, IL;* **70TH ANNUAL MEETING OF THE UNITED STATES-CANADIAN DIVISION OF THE INTERNATIONAL ACADEMY OF PATHOLOGY;** Contact: Nathan Kaufman, Secy.-Treas., U.S.-Canadian Div. of the International Academy of Pathology, 1003 Chafee Ave., Augusta 30904. PH: 404/724-2973.

3-6—*Durango, CO;* **EMERGENCY MEDICINE-TRAUMA;** Category 1 credit; contact: Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

4-6—*Houston, TX;* **MOLECULAR INTERRELATIONS OF NUTRITION AND CANCER;** Contact: Stephen C. Stuyck, Director, Public Information and Education, M. D. Anderson Hospital and Tumor Institute, Houston, TX 77030. PH: 713/792-3030.

8-15—*Maui, HI;* **POSTGRADUATE COURSE IN SPORTS MEDICINE;** Category 1 credit; Contact: Marianne Porter, Center for Sports Medicine, 303 E. Chicago Ave., Chicago, IL 60611. PH: 312/649-7959.

15-16—*Orlando, FL;* **INTERNATIONAL GLAUCOMA CONGRESS;** Contact: American Society of Contemporary Ophthalmology, 6 N. Michigan Ave., Room 1110, Chicago, IL 60602.

19—*Orlando, FL;* **ARTHRITIS-RHEUMATOLOGY SEMINAR;** Contact: American Society of Contemporary Medicine and Surgery, 6 N. Michigan Ave., Room 1110, Chicago, IL 60602.

21-22—*Tampa, FL;* **CONTROVERSIES IN PULMONARY MEDICINE;** Contact: Univ. of So. Fla. College of Medicine, Dept. of Internal Medicine, 12901 N. 30th St., Tampa, FL 33612.

22-25—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Contact: Medical Assn. of Atlanta, 875 W. Peachtree St., NE, Atlanta 30309.

23-25—*Jekyll Island;* **PEDIATRIC OPHTHALMOLOGY;** Contact: Medical College of Georgia Sch. of Med., Augusta 30912.

For additional information on these and other meetings, contact the Education Division, MAG Headquarters, 938 Peachtree St., N.E., Atlanta, GA 30309. Information on upcoming medical meetings should be sent well in advance to the foregoing address.

WANTED:
Physicians who prefer medicine to paperwork.

We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect, where in almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime, where you work without worrying whether the patient can pay or you will be paid, and where you prescribe, not the least care, nor the most defensive care, but the best care.

If that is what you want, join the physicians who have joined the Army. Army Medicine is the perfect setting for the dedicated physician. Army Medicine provides wide-ranging opportunities for the student, the resident, and the practicing physician alike.

Army Medicine offers fully accredited residencies in virtually every specialty. Army residents generally receive higher compensation and greater responsibility than do their civilian counterparts and score higher on specialty examinations.

Army Medicine offers an attractive alternative to civilian practice. As an Army Officer, you receive substantial compensation, extensive annual paid vacation, a remarkable retirement plan, and the freedom to practice without endless insurance forms, malpractice premiums, and cash flow worries.

Army Medicine: The practice that's practically all medicine.

WRITE OR CALL COLLECT:

GEORGIA (Except Augusta Area)

MAJ. Dennis J. Leahy, MSC
HQ, U. S. Army Forces Command
Fort McPherson, GA 30330
(404) 752-2308

AUGUSTA, GEORGIA AREA

CPT. Edward R. Miller, MSC
Dwight David Eisenhower
Army Medical Center
Fort Gordon, GA 30905
(404) 791-6092

An Equal Opportunity Employer



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℂ℣

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk es compered to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have ceused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright ©1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

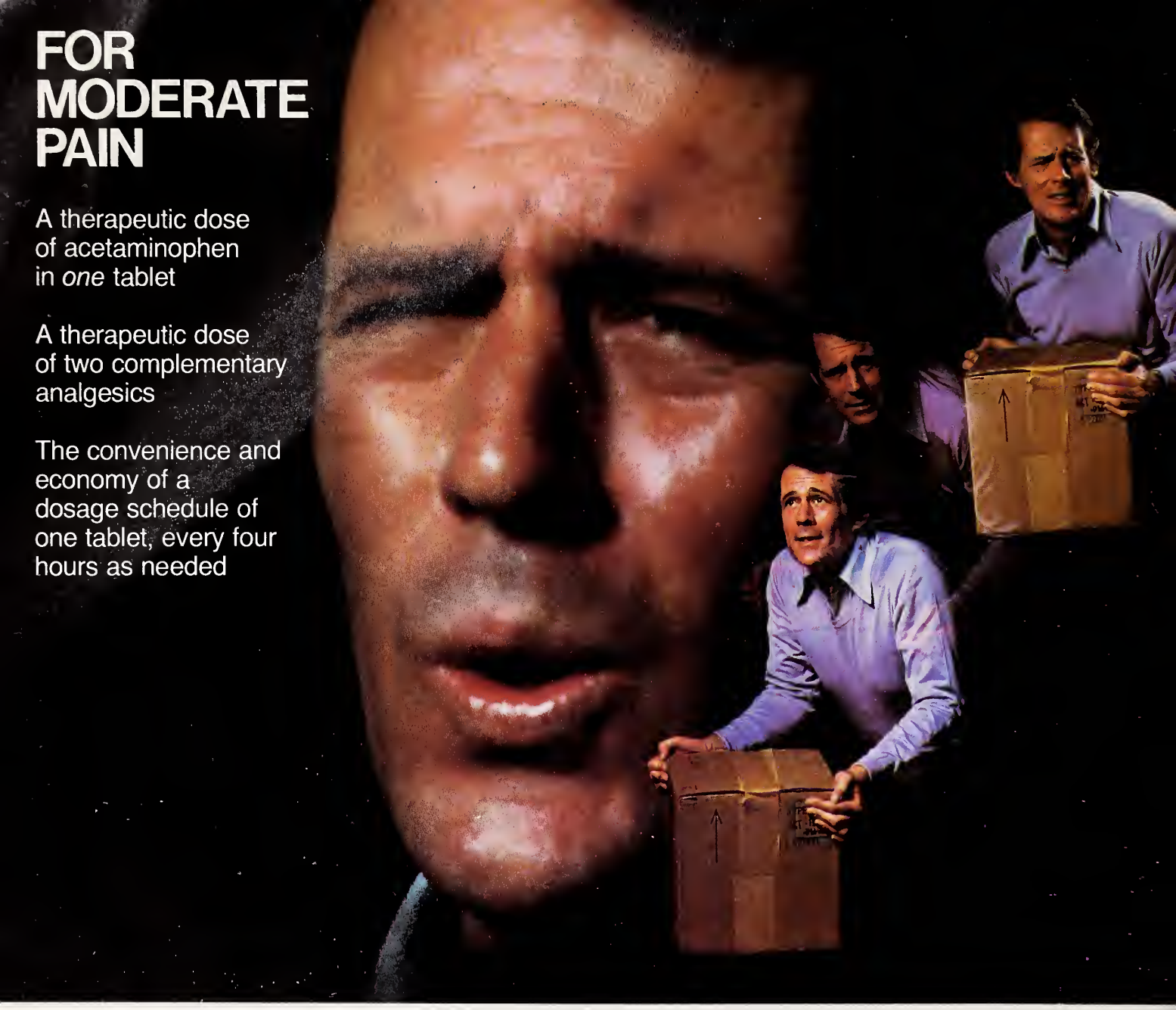
Wyeth Laboratories
Philadelphia, Pa. 19101
™

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® ℠

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Senal hepatic enzyme determinations are also recommended.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa 19101

JOURNAL
of the medical association of
georgia

Specialty and Location of Recent Medical School Graduates in Georgia — Implications for Primary Care

ADAM R. JABLONOWSKI, M.P.A., PHILIP W. RUSSELL, M.S.H.S., SUE A. SETTLES, B.S.H.S., and BONNIE J. KAY, Ph.D., *Atlanta**

Introduction

In January and February, 1979, data were collected from physicians who had graduated from Georgia's then two existing medical schools, Emory University School of Medicine and the Medical College of Georgia (MCG), between Jan. 1, 1974, and Dec. 31, 1978. The purposes of this study were to determine the specialty selection of these physicians and their current practice location and to up-date the Georgia component of national medical school alumni data tabulated by the American Medical Association which ended with the year 1973. More specifically, the study sought to determine the number of medical school graduates selecting family practice as a specialty, the number of Georgia medical school graduates remaining in the state for graduate training, and the indication of any trends in the data for medical specialty choice or practice location site.

The study was completed for the Joint Board of Family Practice with the assistance of students and faculty from the School of Health Systems at the Georgia Institute of Technology. The Board is a state agency created by the Georgia General Assembly to conduct programs to further the supply of competent family physicians in the state and to provide needed medical services to the people of Georgia in underserved areas. In carrying out these functions, the Board conducts programs of family practice education for medical students, development and support of family practice residency programs, and family practice education for medical practitioners. The state funds administered by the Board are used to pay for medical student preceptorships which allow a medical student to undertake a 1-month training experience with a family physician, usually in a rural area. Approximately 100 of these preceptorships are undertaken during the course of a fiscal year. The major Board program involves the provision of capitation payments to teaching hospitals for conducting a family practice residency program. Funds administered by the Board supported 74 residents in four community hospital-based training programs in 1979. As an aid to fulfilling its legal functions, the Board periodically conducts studies and surveys to assist in determining its plans and goals. This paper describes one such survey.

Methodology

The survey sample population was comprised of 1,260 graduates of Emory Medical School and MCG from Jan. 1, 1974, to Dec. 31, 1978. This represented 100% of all graduates in this period. Names and addresses of graduates were obtained directly from the two institutions. Medical Association membership, medical licensure, residency program trainees, and other lists were initially used to determine specialty and location of the graduates. Those alumni for whom a specialty was not identified were

* Mr. Jablonowski is Administrator, Joint Board of Family Practice; Mr. Russell, Miss Settles, and Dr. Kay were with the Georgia Institute of Technology at the time of this study. Send reprint requests to Mr. Jablonowski, Northside Tower, Ste. 612, 6065 Roswell Rd., NE, Atlanta, GA 30328.

TABLE 1 — Comparison of Practice Characteristics, by Year of Graduation

Year Graduated	Column 1 Total Graduates N = 1260, 100.0% n	Column 2 Graduates Practicing in Georgia N = 574, 45.2% n	percent	Column 3 Graduates in Primary Care in Georgia N = 242, 19.2% (unknown = 79) n	percent	Column 4 Difference (2) - (3) percent
1974	214	91	42.5	49	22.9	19.6
1975	233	89	38.2	35	15.0	23.2
1976	275	122	44.4	56	20.4	24.0
1977	253	119	47.0	41	16.2	30.8
1978	285	153	53.7	61	21.4	32.3

contacted either by telephone for those in-state or by mail for those out-of-state. The 1970 census was used to determine the population size of each graduate's practice or training location. Because these were recent medical school graduates, there were relatively few already in practice. The greater number were in training, so that the location of all graduates in the sample cannot be considered a permanent location. Nevertheless, residency location is often a strong influence on eventual practice location, so that the following data represent a fairly good predictor of eventual practice location. Using these methods, specialty and location information was obtained for 85.8% of the sample population.

Data Analysis

A total of 512 (40.6%) were graduates of Emory, and 748 (59.4%) were MCG graduates. Of the total sample, 47.4% were in primary care practices (general practice, family practice, pediatrics, and internal medicine) or in primary care residencies. This compares with a national average of 62% for recent graduates.[1] Slightly less, or 45.2%, of all graduates in the survey were in practice or in training in Georgia. A total of 12.7% (153) located in communities with populations under 15,000.

Distributions of graduates remaining in Georgia and practicing primary care specialties are compared over the 1974-1978 period. Data in Table 1 show a general increasing trend to remain in the state after graduation, with 53.7% for the class of 1978 compared with 42.5% for the class of 1974. No such trend is apparent for the subgroup practicing primary care in the state. An average of 19.2% of all graduates are in this category, with a maximum of 22.9% and a minimum of 15% retention occurring in 1974 and 1975, respectively. In terms of statewide needs, it is not only desirable to retain graduates in Georgia but also to selectively encourage those in primary care to remain.[2] An examination of column 4, Table 1, shows that the opposite trend has occurred since 1974. The gap between Georgia-trained primary care physicians and total practicing physicians has widened from 19.6% in 1974 to 32.3% in 1978.

Rural areas represent traditionally underserved locations by physicians. Georgia has recognized this problem for some time. Recent data show that all of the states' Health Service Areas, except for Area III which includes Atlanta, have physician-to-population ratios of less than the national average. Figure 1 shows how the study population is distributed in Georgia with regard to the population of the practice location. An overwhelming majority are located in metropolitan areas of greater than 100,000 population. These data follow the nationwide pattern. What is perhaps more interesting is how Georgia-trained physicians practicing outside Georgia are distributed.

Figure 2 indicates that, with the exception of sites with more than 100,000 population, Georgia retains less than half of its physician graduates who select lower population practice sites for each category. For communities between 30,001 and 100,000 population, Georgia retains only 18% of Georgia-trained physicians who practice in this size community in other states.

Practice characteristics have been correlated with the type of medical school the physician attended. In a study recently reported by staff of the Association of American Medical Colleges, the medical school attended has an impact on practice characteristics of its graduates through the type of student it selects in addition to providing a direct influence on the student.[3] Tables 2, 3, and 4 examine differences in selected practice characteristics of graduates as a function of medical school attended.

Seven percent more graduates of MCG reported Georgia practice sites than did Emory graduates (49.4% compared with 42.6%). MCG graduates settled in communities of 15,000 and under to a slightly higher degree than did Emory graduates (13.5% compared with 11.6%). The same pattern continues when the distribution by specialty is compared. A total of 47.9% of MCG graduates are practicing in

Figure 1. Distribution of Survey Population Practicing in Georgia, by Population of Practice Location.

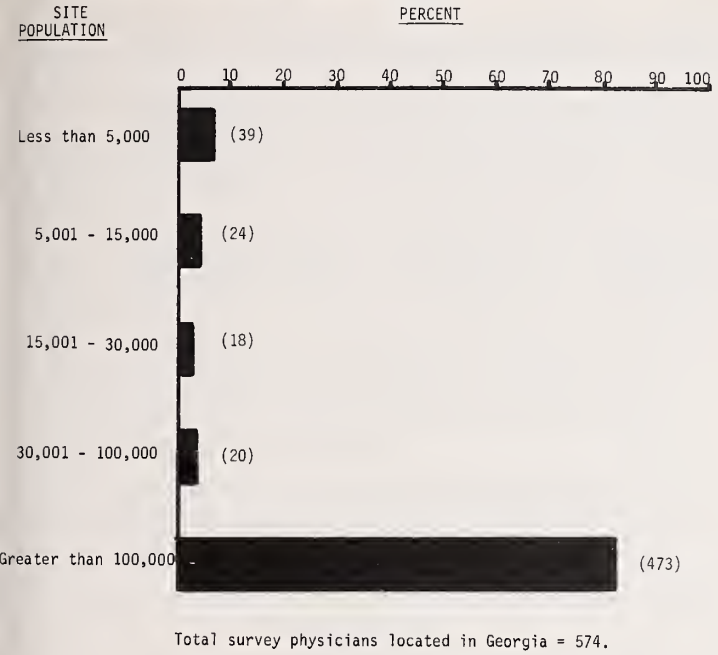
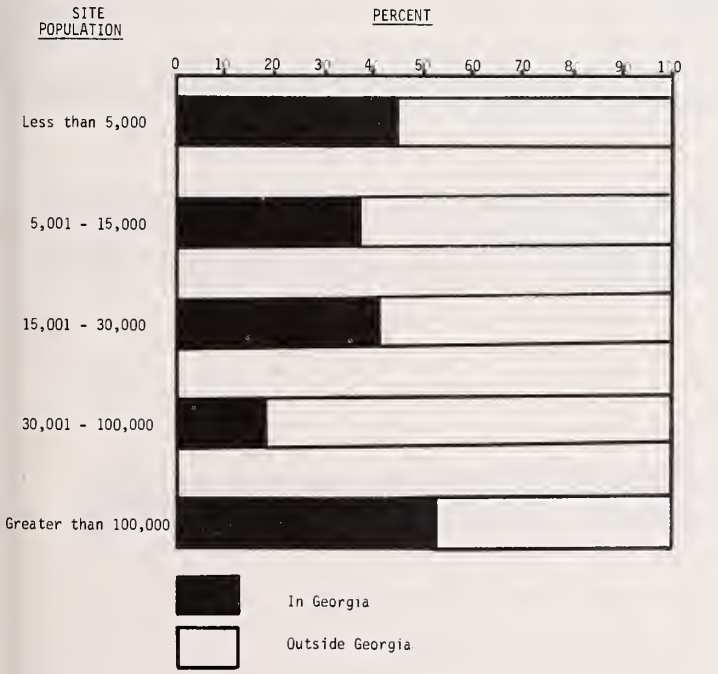


Figure 2. Distribution of Survey Population, by State and Population of Practice Location.



primary care specialties, compared with 46.3% for Emory graduates. With the exception of state-of-practice location, none of these differences are statistically significant at the 0.05 level of probability.

When primary care is disaggregated into general practice, family practice, pediatrics, and internal medicine, significant differences do appear (Table 5). Most notable are differences for family practice and internal medicine, with MCG graduates selecting family practice at over three times the rate of their Emory counterparts and Emory graduates selecting internal medicine almost 1.5 times as frequently as MCG graduates.

TABLE 2 — State-of-Practice Location for Emory and MCG Graduates of Classes 1974-1978

	Medical School			
	Emory		MCG	
	n	percent	n	percent
In Georgia	218	42.6	356	49.4
Outside Georgia	294	57.4	364	50.6
	512	100.0	720	100.0
Cases unknown	0		28	

$X^2 = 5.3966$; $p = .0202$; $df = 1$

TABLE 3 — Size of Practice Location for Emory and MCG Graduates of Classes 1974-1978

	Medical School			
	Emory		MCG	
Size of Community	n	percent	n	percent
0-15,000	59	11.6	94	13.5
>15,000	450	88.4	604	86.5
	509	100.0	698	100.0
Cases unknown	3		50	

$X^2 = .7738$; $p = .3791$; $df = 1$

TABLE 4 — Practice Specialty for Emory and MCG Graduates of Classes 1974-1978

	Medical School			
	Emory		MCG	
Specialty	n	percent	n	percent
Primary Care	201	46.3	310	47.9
Non-primary Care	233	53.7	337	52.1
	434	100.0	647	100.0
Cases unknown	78		101	

$X^2 = .2065$; $p = .6491$; $df = 1$

TABLE 5 — Primary Care Specialty for Emory and MCG Graduates of Classes 1974-1978

	Medical School			
	Emory		MCG	
Specialty	n	percent	n	percent
General Practice	13	6.5	15	4.8
Family Practice	17	8.5	90	29.0
Pediatrics	27	13.4	47	15.2
Internal Medicine	144	71.6	158	51.0
	201	100.0	310	100.0

$X^2 = 34.312$; $p = .0000$; $df = 3$

Discussion

In spite of the efforts being made nationally by federal government funding and through the financial support of private foundations for primary care and particularly family practice, there is little indication of any significant effect in Georgia thus far. The percentage of Georgia graduates entering primary care is 47% overall, with 19% remaining in Georgia which is considerably less than the 50% recommended by the Institute of Medicine. Furthermore, one must bear in mind that a certain percentage of the internal medicine and pediatric physicians will be entering a sub-specialty field, thus further reducing the 19% figure. In looking at the percentage for family practice, Emory — 4% and MCG — 14%, even more concern must be expressed. The Institute of Medicine has recommended that 25% of medical school graduates should be entering the specialty of family practice. The figures in Georgia do not approach these suggested levels.

One would anticipate that the location of graduates would generally be in larger communities shortly after graduation, because these are the sites of their training institutions. The practice site data show that 75% (900/1207) are located in the largest urban category (over 100,000 population). Perhaps the most interesting finding on location is that over half of the graduates obtain their graduate training outside Georgia. This should be of particular concern since, generally, a physician establishes a practice site in close proximity to his or her graduate training location. With the potential loss of so many medical school graduates, a number of questions can be raised about graduate medical training in Georgia. Are there a sufficient number of slots? Is the training in the desired specialties? Does the quality of training compare favorably with that found in other states? And, finally, what are the criteria used by graduates for residency program selection and how well do Georgia's programs meet them? Accessible primary care has been a nationally recognized priority for some time. Recent trends in Georgia as suggested by data from this survey present a pattern which should be of some concern to all those involved in medical education and health planning in the state.

References

1. National Resident Matching Program Directory. Evanston, Illinois, October, 1978, p. 18.
2. Georgia State Health Planning and Development Agency: Overview of Health in Georgia. (Unpublished draft of state health plan.)
3. Erdmann JB, Jones RF, Tonesk X. AAMC Longitudinal Study of Medical School Graduates of 1960. National Center for Health Services Research, Research Digest Series, DHEW Publication No. (PHS) 79-3235, January, 1979.

IRA, Keogh— enjoy today while you plan for tomorrow.

Fulton Federal's IRA is designed for you if you are self-employed or employed but not presently covered by a qualified retirement plan.

With IRA (Individual Retirement Account), you can plan for tomorrow by contributing as much as 15% of your compensation (or earned income if you are self-employed) not to surpass $1500 in any one year. IRA allows your savings plus interest to be compounded and tax deferred until retirement or age 59-1/2. Consequently, when you do begin withdrawing money, you will probably be in a lower tax bracket, thus your taxes will be less.

Keogh is designed for you if you are self-employed. With the Keogh retirement plan, your savings plus interest is also compounded and tax sheltered until time of withdrawal. You may deposit 15% of your earned income, not to exceed $7500 in one year.

For more information, call Fulton Federal's Retirement Plan Counselors at 586-7031. IRA and Keogh, two ways to plan for tomorrow.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta • P.O. Box 1077 • Atlanta, Georgia 30370

70 GEORGIA PROVIDERS HAVE SOLVED THEIR MEDICAID PROCESSING PROBLEMS.

MEDICARE, YOU'RE NEXT!

Our unique computerized system has reduced the Medicaid claim turn-around to 12 days.

Call or write for more information on paperless claims processing.

- IMPROVED CASH FLOW
- REDUCTION IN PAPERWORK
- ELIMINATION OF LOST CLAIMS
- PROVIDER CONTROL
- PURITY OF DATA

Emerson Center
2814 New Spring Road, Suite 121
Atlanta, Georgia 30339
(404) 436-2121

MD
Med Data Ltd.

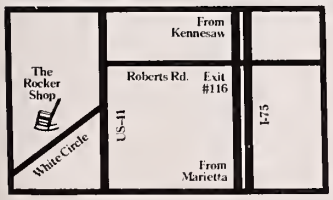
ROCKING THE NATION FOR OVER 100 YEARS...THE ONE AND ONLY BRUMBY ROCKER, ONLY AT THE ROCKER SHOP.

Few things have withstood the test of time as the Brumby Rocker. From it's early southern heritage, to today's White House, the Brumby has established a reputation as the world's finest handcrafted rocker. The moment production begins, to the moment we sell it to you, the Brumby is treated with the finest skill and care. The same skill and care used over 100 years ago when Brumbys were first made in 1875.

A Brumby Rocker is an investment in a future family heirloom. In fine homes throughout the country it has become a part of the family, rocking generations of children and a source of relaxation for all.

What gives the Brumby this enduring popularity? It begins with fine grained, solid oak which is half air dried and half kiln dried for natural expansion and contraction which helps prevent warping or bending. "Blue Tie" cane from Singapore is hand woven on both sides of the seat and back for comfortable cushioning and beauty from every angle. The steam bent back posts are curved to naturally cradle your back. The extra wide runners are designed with a slight rear arch to give an even rock and help prevent tipping. The man-size arms, with the original Brumby seal, let you rest your elbows comfortably. All are hand-sanded to a warm finish that accentuates the fine grained wood.

Good things are hard to find, but always well worth the search. If the Rocker Shop is a little out of your way, we'll gladly ship your Brumby Rocker anywhere. Major credit cards accepted.



The Rocker Shop of Marietta Georgia

1421 White Circle, N.W. • P.O. Box 12
Marietta, Georgia 30061 • (404) 427-2618





"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Desprēaux

PAVABID® AND PAVABID® HP

(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY MO 64137

6/80

National statistics suggest a 75% successful sperm count after vasovasostomy, with a 40%-60% rate of conception.

Too Bad For You, Humpty Dumpty

WILLIAM J. MORTON, M.D., ***Atlanta****

"Humpty Dumpty sat on a wall,
Humpty Dumpty had a great fall,
All the King's horses and all the King's men,
Couldn't put Humpty together again."

I BET THEY COULD if they had known about microsurgery. Time continues, knowledge expands, and, as with our own maturity and experience, medicine also becomes more knowledgeable, more mature, and more expert. We all know that we must continue to actively update our own medical education, or we shall stagnate. This brief report will acquaint you with one microsurgical technique which is successful, becoming more popular, and about which all of us should be more familiar.

Description: What, Who, and Why

Vasovasostomy, reapproximating the ends of the vas, vasectomy reversal — call it what you will — it is here to stay. This procedure was first reported in urologic literature in 1948 and is being performed with impressive results throughout the country. For whatever reason, changing social mores, early widower, a change of attitude toward parenthood (I have done vasovasostomies for all the above reasons), requests for vas reversals are becoming more frequent. Ten years ago, in counselling a patient for a vasectomy, I stressed the irreversibility and permanency of the operation. Although I do not tell prospective vasectomy patients that there is a possibility of reversing the vasectomy, I no longer stress its complete permanence.

The average age of men who have vasovasostomies is 36, with the average interval from vasectomy to vasovasostomy being 7.6 years. The post-vasovasostomy semen analysis shows uniform results in that the count is usually on the lower side (30 million), the motility is markedly reduced, and the morphology is abnormal in at least 50%. (This is the type of stress pattern seen in the semen of patients with varicocoele which would ordinarily suggest a surgical approach to improve the semen quality.) In the post-vasovasostomy patients, the quality of semen is usually sufficient to effect conception.

The success rate of vasovasostomy can be measured either technically or functionally, and they sometimes conflict. A technically good result can produce a high sperm count, with good motility and morphology, but be functionally unsuccessful in that no pregnancy results. National statistics suggest a 75%-successful sperm count, with a 40-60% rate of conception. Some of the reasons for failure to conceive could be a sterile partner, stricture at the vasovasostomy site, sperm agglutination, immobilization, or anti-sperm enzyme antibodies.

My Mode of Operation

Briefly, I shall describe my method of vasovasostomy. The patient is admitted to the hospital, and the procedure is done under a general anesthetic. It usually takes about 2 hours (compared with 10 minutes for a vasectomy). After a small mid-line scrotal incision, I find each vas with its scarred vasectomy site. I then dissect this scar out and have the proximal and distal vas isolated. One should be careful about stripping the blood supply of the vas so as to not necrose it. Usually a creamy effluent comes from the proximal (testicle side) vas, which has dead and disintegrating sperm in it. I use 3.5x magnifying loupes and 8-0 ophthalmic black braided silk. I find that the ophthalmology needle holders and pick-ups

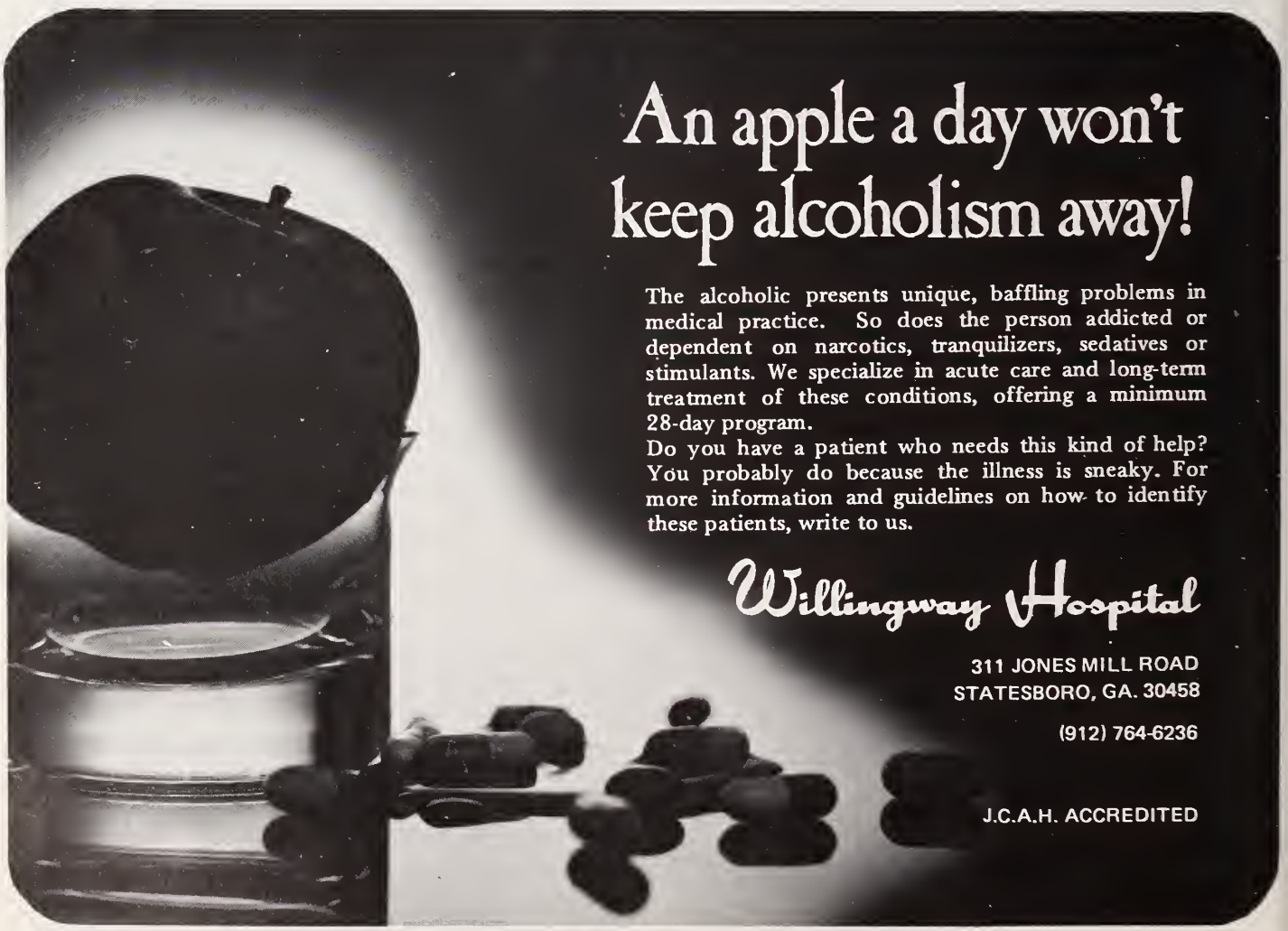
* Dr. Morton practices urology. His address is 4553 N. Shallowford Rd., Ste. 80-C, Atlanta, GA 30338.

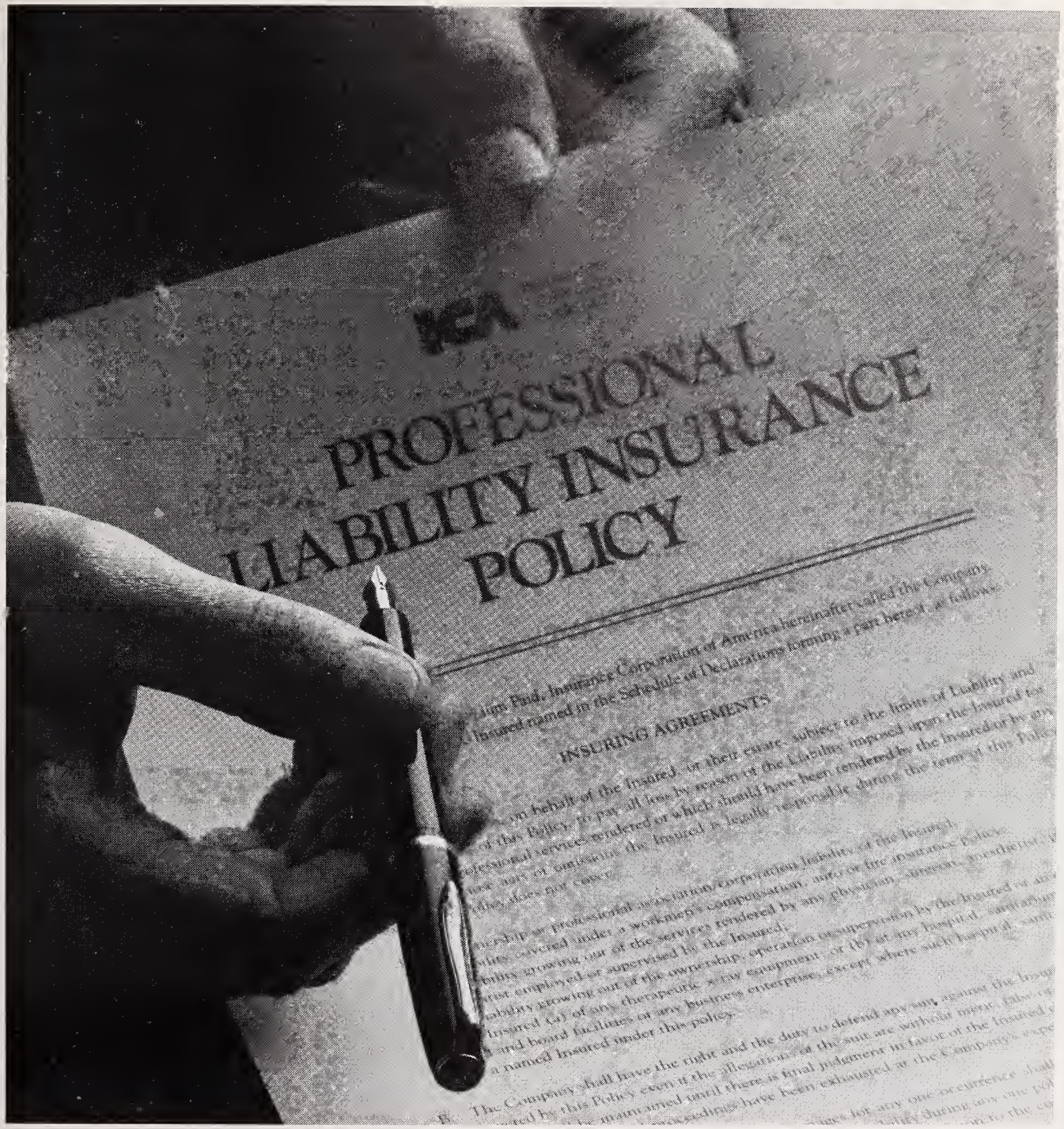
are best for me. I then use two sutures taken 180 degrees apart directly through the muscularis and the lumen to exactly approximate both proximal and distal lumens. The proximal lumen is usually dilated slightly. This is because of the continued production of sperm after the vasectomy. I have on one occasion obliquely cut the distal vas so that the two lumens would approximate more evenly, but this is usually unnecessary. At least six more 8-0 sutures are then taken circumferentially through the muscularis of the vas. No intralumenal splints are used. One nice thing about this operation is that if for some reason one side does not go well technically, you get a second chance on the other side. The skin is then closed with one subcuticular suture of 4-0 dexon. Although an exact approximation of the proximal and distal lumen is usually readily attainable, I keep the patient at strict bed rest for the next 36 hours so as to decrease the chances of disruption of the anastomotic site. A semen analysis is done monthly, and I advise the patient that it may take 6 months to a year for his sperm count and total semen analysis to become of such quality that he can impregnate his partner.

With the changing social climate in this country and the natural advancement of surgical technique and experience, vasovasostomy is an additional procedure to be added to the surgeon's armamentarium. In our role as physicians, we must not only apprise our patients of the newest aspects in the advancement of medicine, but we should be prepared to either perform these technical procedures ourselves, or at least have a working knowledge of the subject so we can advise our patients.

References

1. Middleton RG, Henderson D. Vasovasostomy and semen quality. J Urol 1980; 123:518.
2. Fernandes M, Shale KN, Draper JW. Vasovasostomy: improved microsurgical techniques. J Urol 1968; 100:763.
3. Sullivan MJ, Howe GE. Correlation of circulating antisperm antibodies to functional success in vasovasostomies. J Urol 1977; 117:189.
4. O'Connor UJ. Anastomosis of the vas deferens after purposeful division for sterility. J Urol 1948; 59:229.





PUT A CONTRACT OUT ON FRIVOLOUS CLAIMS.

Frivolous claims can be a nightmare. Especially if your malpractice insurance company doesn't stand by you. And unfortunately, all too many don't.

For instance, most malpractice insurance policies give you no say in whether to fight or settle a claim. And if you do have a say, you can be hit with a costly penalty for going to court. Another thing. Many companies don't pay all legal expenses. And most companies seldom use lawyers to process cases. Claims are often handled only by claims adjusters.

It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working for doctors. So we know the strong coverage and knowledgeable service physicians need from their liability insurance. And since we specialize in this one field, we can offer a superior policy for a realistic premium. Premiums based on actual costs in your state.

So select the policy with the protection you need. Put a contract out on frivolous claims. For more information contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas Phone 1-800-231-2615

ICA INSURANCE CORPORATION OF AMERICA

MALPRACTICE INSURANCE
IS BETTER TODAY. BECAUSE OF ICA.

An interesting account of a talented and dedicated physician who contributed much to the medical care of Confederate soldiers.

The Medical Career of Samuel H. Stout — Part I

JULIA EMMONS, *Atlanta**



Samuel H. Stout, M.D., was a rural general practitioner prior to the Civil War. His extraordinary administrative capabilities came to fruition during the war, as he went from heading up one small hospital to becoming Medical Director of Hospitals in the Confederacy. He was a dedicated physician who visited home only three times during the war and finally returned to a home destroyed.

TWENTY YEARS AGO, H. H. Cunningham observed in *Doctors in Gray* that, "illustrative of the great need for research in medical history is the fact that no adequate biography of any of the Confederacy's leading medical figures has as yet appeared."[1] Though the last 2 decades have witnessed some attempts at filling this gap, such as Breedon's well-received biography of Civil War doctor-scientist Joseph Jones,[2] much remains to be done. Other than sketches in the *Dictionary of American Biography* and one or two other collective biographies of turn-of-the-century vintage, there are no studies of men of such major importance as Surgeon General Samuel Moore or Medical Director of the Army A. S. Foard.

Another leading figure in the medical administration of the Confederacy, Samuel H. Stout, Medical Director of Hospitals, has also been largely ignored by scholars despite the existence of a large body of manuscripts and autobiographical material that gives detailed outline of his Civil War career and activities. Stout's is a life worthy of study. Though the pre-war and post-war portions of his career follow somewhat traditional patterns, his outlook and activities during the conflict between the states indicate that he was a doctor of unusual administrative ability who fully understood the need for order and discipline amidst the chaos of wartime conditions and had the gifts and the power to enforce them. In addition, Stout, though only a country doctor before the war, was trained well enough and was adequately familiar with current medical developments that he was able to introduce innovations and modifications into hospital organization that reflected advanced scientific medical opinion of the day. The biography of Samuel Stout is thus the story of a rural practitioner who was thrust into an arena which revealed his unusual administrative and intellectual skills. The tragedy of his story is that once the conflict was over, he never found a niche in the postwar world that made adequate use of his talents.

In the Beginning

Stout was born into a well-to-do Nashville family on March 2, 1822. His father, Samuel Van Dyke Stout, founded the first carriage factory in Nashville and was mayor of that city in 1841. His mother, the former Catherine Tannehill, was the sister of Wilkins Tannehill, whom one pair of historians have

* Ms. Emmons is an Associate Professor of Librarianship in the Division of Librarianship at Emory University and is also in the Ph.D. program in the History Department there. Her current temporary address is 21, Gerrard Rd., Islington, London N1, England. The second part of this paper will appear in the December issue of the *Journal*.

described as "the leading literary man of that time in Nashville"[3] and whom a descendent recalled as "in his day the most distinguished mason in the valley of the Mississippi."[4] The young Stout received the traditional early education of the upper middle class of his day. He prepared for college by attending a classical and mathematical seminary headed by Moses Stevens, a Nashville schoolmaster, who had run the academy for over 2 decades.[5] At 13, Stout entered the University of Nashville; in 1839, at age 17, he was awarded the A.B. and in his twentieth year received the A.M. from the same institution.

After graduation, Stout returned to Stevens' seminary as a teacher. He did not devote full attention to schoolmastering, however, for he also began studying medicine under his brother, Dr. J. W. Stout, and his partner, R. C. K. Martin. In 1842-3, he turned his attention more fully to medicine and attended one course of study at the University of Pennsylvania. Stout seems to have felt at home at this northern university. Reminiscing in later years of this experience, he recalled, "there were about one thousand students in the medical department of the University of Pennsylvania and Jefferson College. Of these, nearly half were from the slave-holding section. It was rare to find among the latter an individual who was not a Bachelor of Arts, or fairly educated in the classics, mathematics, natural philosophy, and chemistry prior to attending upon the study of medicine."[6] Upon his return to Nashville, Stout resumed his dual career by becoming principal of a classical and mathematical seminary in Elkton, Giles County, Tennessee, and pursuing medical study.[7]

Among the students in the medical department of the University of Pennsylvania in Jefferson College in 1842-3, nearly half (500) were from the slave-holding section. Nearly all of these were "a Batchelor of Arts, or fairly educated in the classics, mathematics, natural philosophy, and chemistry prior to attending upon the study of medicine."

In 1847, Stout returned to the University of Pennsylvania to conclude his medical study. Passes to lectures included in the Stout manuscripts at Emory University show that Stout registered for "Theory and Practice of Medicine and Clinical Practice" given by N. Chapman, M.D., "Materia Medica and Pharmacy" taught by Dr. George B. Wood, "Anatomy" given by Dr. W. E. Horner, and "Chemistry" delivered by Dr. Robert Hart.[8] He was also the private pupil of Dr. Rease, Dr. Edward Peace, and Dr. John Neill. The latter was an assistant demonstrator in anatomy at that time and later became the first professor of clinical surgery at the University. The fourth man under whom Stout studied privately was William Wood Gerhard (1809-1872), one of the most famous research physicians of his day. Gerhard had studied in Paris with Pierre Louis, a leading French clinician-pathologist who, in the words of medical historian Donald Fleming, was "the irresistible magnet who drew men across the Atlantic for a generation to learn the 'numerical method' — close observation in the wards and exhaustive autopsies, recorded in tables and subjected to statistical analysis."[9] Through these methods, Louis had arrived at a new understanding of the nature of typhoid. Gerhard, upon his return to America, added to the discoveries of his mentor by bringing to light the difference between typhoid and typhus and thus producing, according to Fleming, "the great positive achievement of the school of Louis in America."[10]

As Gerhard's private pupil, Stout made clinical rounds with the famous researcher whose observations Stout jotted down in a small suede-covered notebook that remains with the Stout papers. A number of patients were observed on each round suffering from a wide range of ailments. For example, one day they saw at least 13 patients whose troubles ranged from an 18-year-old with "swelled feet" to a man from Vera Cruz with "chronic diarrhea." In the same group, a Mrs. Turfet had "ovarian dropsy," while Valentine Seltzer, age 30, had typhoid fever. For each patient, Stout recorded the disease, the appearance of the patient, and the medicine prescribed by Gerhard.[11]

After concluding his studies at Pennsylvania in 1848, the 25-year-old Stout took the examination for commission as assistant surgeon in the U.S. Navy. He received the highest score out of the 52 applicants and received his commission 2 days before he was awarded his M.D. degree.[12] Stout did not accept the commission, however, and wrote the Secretary of the Navy that, "I have been compelled by domestic and private considerations of the most sacred character unforseen at the time of application for the office — to decline the acceptance of a commission."[13] A later biographical sketch of Stout suggests that these "sacred" considerations turned on the fact that the Mexican War was over by then and opportunities to gain valuable field experiences were thus diminished.[14]

Setting Up Practice

Stout returned to Nashville and shortly thereafter married Martha Abernathy, the daughter of Thomas S. Abernathy of Giles County. For a brief period, he practiced medicine with his brother, and then, in 1850, deciding upon a more rural practice, he bought a farm in Giles County, midway between Pulaski and Elkton. There, according to his daughter, he "pur-

sued his profession in the midst of a well-to-do and appreciative clientele, and made a phenomenal success both as a farmer and a general practitioner of medicine."[15] Stout took on community duties as well, helping to organize the Tennessee Medical Society and serving as its secretary.

According to his daughter, Stout "pursued his profession in the midst of a well-to-do and appreciative clientele, and made a phenomenal success both as a farmer and as a general practitioner of medicine."

These were good years for Stout, especially when contrasted with those that followed. Writing in 1893, at the age of 71, Stout published a reminiscence of what life had been like for the rural upper-middle class doctor before the Civil War:

> *The average medical man in the well-to-do agricultural regions of the South and the Northwest was, in general, well-educated in the arts, and well-grounded in the principles of medical science. Combining agriculture and the practice of his profession, he was generally prosperous. Practicing for his neighbors of all classes, both rich and poor, he was a friend to all, and in general an advisor, in regard to matters social, educational, and political. He had an office to which his patrons often resorted to discuss the topics of the times. He had a library of miscellaneous books, as well as medical. He was a subscriber to newspapers and literary magazines as well as to medical journals, and those, too, that were the very best of their kind. . . .*
>
> *The distance of his practice from his home precluded the possibility of frequent visits to their bedsides. Therefore the scientifically educated practitioner in the rural sections took great care in making his diagnosis, and studied pathology with zealous intelligence. His therapy, so far as he had to depend upon materia medica, he learned to simplify. Because he had to carry medicine in saddlebags, he learned to do a successful practice with a few of the most reliable medicines of the Official List, in the proper dispensing of which he acquired accuracy as to the doses needed in each case. With the numerous domestic remedies in use among the people, he became familiar, and often presented them, and that, too, with satisfactory results. . . .*
>
> *The educated rural practitioners practiced all branches of their profession. They, for the most part, did their own surgery, and did it satisfactorily, too, with the simplest of appliances and apparatus, and a few instruments as was compatible with the performance of good work.*[16]

The coming of the Civil War shattered Stout's tranquil world. In May, 1861, shortly after the secession of Tennessee, he joined the Provisional Army of Tennessee as a commissioned surgeon. He was to visit home only three times in the next 4 years and in the end returned to find his home destroyed.

Adapting to the Military

The circumstances of war changed Stout from a prosperous rural practitioner to one of the most important and powerful doctors in the Confederacy. The beginnings of this extraordinary change were modest. Nevertheless, Stout's approach to the problems at hand, even in his first assignment, prefigured what would follow.

On May 5, 1861, Stout reported for duty as head of the hospital of the 3rd Tennessee Regiment, quartered at Bowling Green. His troubles began immediately. The regiment consisted of some 1,100 men, mostly youths from rural areas, who had never been exposed to measles. Stout had not been in camp long before nearly half of them were down with the disease.[17] Stout's reasoned efforts to deal with the disease met some unexpected resistance. The patients were often hostile to his treatment methods. "The crude ideas of officers and men, and of their relatives and friends (many of whom rushed to the camp), of the pathology and treatment of the disease," Stout later wrote, "produced a panic, preventive of wholesale discipline and in many instances, in spite of the protestations of the medical staff, to traditional malpractices. For most of our rural people then believed that a measles patient should be kept heated with hot teas and an alcoholic stimulant, and not exposed to a breath of moving air. To be sick with measles in a tent or under a bush arbor in pleasant weather was, in their opinion, surely provocative of fatal results."[18] Despite such resistance to modern methods of treatment and the presence of swarms of well-meaning though ineffective and disruptive people, Stout and his fellow doctors managed the epidemic successfully, and not one person died.

This crisis over, Stout set about organizing the medical service in the camp according to army regulations. Stout had studied the regulations to pass the exam for the naval commission in 1848, and he felt strongly, as will be illustrated amply below, that sound discipline and obedience to the rules were essential to the effective running of a military hospital. He felt that this prior study gave him an advantage over many other newly recruited medical officers. In a third person description of himself, he later wrote:

> *Understanding the regulations of the medical*

department of the army, he did not, from the beginning of his service, find difficulties in organizing his regimental hospital, disciplining the sick and wounded, making requisitions for supplies and quarters, or in the assertion of his true relationship to the Medical Director and the Surgeon General, with officers in command of troops, with commissaries, quartermasters and purveyors, which often wearied and worried many most worthy surgeons, just from civil life, whose ignorance of the army regulations was profound, because they had never seen a copy thereof, nor had their attention called to them before they found themselves amid the sick, wounded and dying, powerless to provide for their comfort and ease to the extent it was their desire to do. Their distress was sincere and painful.[19]

Stout's own efforts at such rationalization of procedures was a success: "I soon secured order," he wrote, "[and] . . . I was able to demonstrate to all the value of the humane discipline prescribed in the army regulations."[20] By that autumn, according to his memoires, his was the only regimental hospital organized and administered in accordance with army regulations.[21] Such was his feeling of success at Bowling Green that he suggested to the Medical Director of the Army that the Director send all newly appointed surgeons to Stout's camp for instruction. Stout later remarked that the Director "gratefully accepted" and for some months the hospital was used as an "object lesson for the instruction of surgeons unacquainted with the regulations."[22] Stout's example must have seemed one of the few bright spots in what Cunningham describes as an early hospital picture that "was confused and depressing."[23]

One of Stout's most important contributions to the Confederacy was his organization and management of hospitals according to army regulations.

In the fall of 1861, the medical hierarchy decided to close the regimental hospitals and open general hospitals in Nashville and other urban centers, transporting all sick and wounded there. David Yandell,[24] the Medical Director of the Army upon whom Stout had made such a favorable impression, appointed Stout surgeon in charge of the Gordon Hospital, so named because it was housed in Nashville's former Gordon Warehouse. In a letter written that December, Stout attributed his appointment to "my knowledge of the regulations of the Army and my disciplinary skill."[25]

The warehouse hospital Stout took charge of was in a chaotic state both physically and administratively. Ventilation was poor; there were no openings in the building at the rear or side ends, only a front door and windows and one skylight providing what fresh air there was. In addition, the sanitation facilities were inadequate and in disrepair. The organization of the hospital was little better. Stout thus later recalled the situation:

The hospital seemed to be in charge of a committee of ladies of the Nashville Hospital Association . . . kind, benevolent and self-sacrificing ladies. How they were over-taxed, over-worked! Unacquainted with the workings of the rules necessary to be observed in the management of a military hospital, it was not astonishing to me that they at first were disposed to resist my efforts to remedy the prevalent confusion and to demonstrate the value of system and military discipline.

The patients were being treated by civilian physicians called in by the ladies' committee. I found a number of them with prescription papers in hand busy writing their prescriptions, which were taken by the ladies to local pharmacists to be filled.

As before said, there was no register, no record made of the diagnosis of the cases, no record of prescription written, and no diet table.[26]

Stout rose to the challenge. His first effort was to gather accurate information on each patient.[27] Somewhat to his surprise, he found his program offended the ladies for, as he later put it, "having preceded me in charge of the hospital, they were somewhat disposed to be resentful of my authority. They based their right of control on a letter of the Surgeon General to their President, giving them full access to the Confederate hospitals and commending them to the courtesy of the medical officers in charge."[28]

Undaunted, Stout maneuvered for control. The poor plumbing of the establishment gave him his opportunity. When blocked pipes forced the evacuation of the hospital, Stout seized the chance to not only disinfect the building but also to reorganize the workforce upon its return. The ladies found they had nothing to do except prepare the diet of the very sick and were informed that they had to submit to army regulations. They did not do so without a fuss. "The ladies, after consultation, delegated one of their number to wait upon me and find out what I meant by thus thwarting them in their benevolent, self-assigned work," he later recalled. "She was a venerable and highly estimable lady. She had known me from infancy. . . . " He finally convinced her of his authority, assuring her that, "I sincerely desired the aid and cooperation of the good ladies of the Society,

but their opposition I would not brook. . . . '' ''This frank conversation,'' he found, ''brought about a mutual understanding between the ladies and myself, and they became cooperative.''[29] In order to maintain his victory, Stout kept accurate accounts of hospital funds and was able to provide all that was needed for the hospital without relying on the Ladies Hospital Association for money. In addition, he found that the smell of onions he ordered the patients to eat ''as an antiscorbutic'' was offensive to some of the ladies and made them less eager for hospital duty.[30]

Stout remained in charge of the Gordon Hospital until April of the following year. His view of his duties can be surmised from a circular he sent out to other surgeons-in-charge later in the war. In it he outlined that the senior surgeon had authority over all medical officers in a hospital and was responsible for even the smallest detail. His was the right to control medical practice, and if possible he was to visit every ward on a regular basis. The running of each surgeon's hospital should be so systematized that such visits could be made, thus allowing the surgeon to follow the course of treatments. In addition, the surgeon-in-charge was to examine those that died under his care and to be aware of the cause. The assistant surgeons were responsible for the actual running of the wards and were to see that all other personnel — stewards, nurses, cooks — performed their duties well. By following such guidelines, Stout felt that the surgeons could ''aid in the performance of the duty incumbent on us all to purify and devote our noble profession and to throw as many safeguards as possible around the lives of the defenders of our homes, our rights, and our liberties.''[31]

''A private introduced me to Brig. Gen. S. B. Maxey. I said to the General that I had been sent to that place (Chattanooga) to take charge of the hospitals, but I could find no one to whom to report. He replied, 'I was sent here to command this post, and, as yet, have found no one to command.' ''

Stout's directorship of the Gordon Hospital was terminated by the fall of Fort Donelson in February, 1862, and the ensuing threat to the city of Nashville. Nearly 4 decades later Stout still recalled ''the scenes witnessed at Nashville on the memorable Sunday of the surrender of Fort Donelson and the almost utter confusion, not to say demoralization of the hospital service.''[32] Stout did not want to stay in Nashville once he had vacated the hospital; he did not wish to witness the take-over by federal troops. He therefore requested General A. S. Johnson for transfer elsewhere. The General sent him to Chattanooga, to fill a position of increased responsibility as post surgeon. In Stout's own words, his new task was ''to clean up the hospitals in Chattanooga, which . . . were in a very unclean condition; and send all patients able to travel to Atlanta, Georgia, for treatment, as Chattanooga was then in a very filthy condition, and its salubrity very inferior to that of Atlanta. . . . ''[33] Before taking up the challenges of this new position, however, he took a month's furlough. It was to be one of the only three times he visited his family during the conflict.

Post surgeon Stout arrived on the job March 22, 1862. Much to his alarm, as he later wrote, ''save the few patients on hand, I could find no soldiers, or officers, no commander of the post, no quartermaster, no commissary, and no provost marshall. In the afternoon of the second day after my arrival,'' he continued, ''a private introduced me to Brig. Gen. S. B. Maxey. I said to the General that I had been sent to that place to take charge of the hospitals, but I could find no one to whom to report. He replied, 'I was sent here to command this post and, as yet, have found no one to command.' ''[34]

''Most of the injured men arriving at the post were sent along by rail to Atlanta.''

Despite this inauspicious beginning, Stout set about organizing efficient medical service for the post. Chattanooga's one hospital was the Academy, a confused entity containing but a dozen patients, one assistant surgeon, and one contract physician. There was no quartermaster and no commissary. Most of the injured men arriving at the post were sent along by rail to Atlanta. It quickly became obvious to Stout that many of the injured could not safely make the trip, so local facilities needed to be improved and expanded. He therefore reorganized the hospital according to regulations, training the personnel and obtaining the necessary services of a quartermaster and a commissary. In addition, he set up the Newsom Hospital[35] in an old hotel, modelling its organization along the Academy's lines.

By July, 1862, Stout had his two hospitals in good working order. That month General Braxton Bragg[36] visited the post. Unannounced, the General paid a visit to the Academy and Newsom hospitals. Bragg and Stout had never met. Stout later recalled that ''I have seen many inspecting officers but General Bragg is the most thorough inspector I have ever met with. He did the inspecting in person,'' Stout continued, ''the other officers for the most part looking on. He inspected every bunk, turned down the coverlets and sheets, and even looked under the bunks. He inspected the medicines, the kitchens and outhouses,

and looked over the register, the prescription, diet, order and case books. I never saw anything like such an inspection.''[37] Later that afternoon, Stout received an order to report to headquarters. Upon Stout's arrival, Bragg's Medical Director, A. S. Foard told him, as reported by Stout, that ''General Bragg ordered me to send for you and to say to you that after a thorough inspection of the hospitals in Chattanooga, he is highly pleased with them, and that they are the only hospitals he has seen since he left Pensacola that were fit for the treatment (successfully) of soldiers.''[38] In reply to Foard's following question as to where Stout had picked up such skills, the post surgeon pointed out he had once prepared for a naval commission and thus understood and valued military regulations.

Precision Leads to Promotion

Bragg's commendation, however, did not stop with a few kind words. Three days later, he issued a special order, announcing, ''S. H. Stout, Senior Surgeon of the Post of Chattanooga will, subject to the orders of the Medical Director, have the general superintendence of all hospitals which have been, or may hereafter be established in the District of the Tennessee — which includes those at Chattanooga, Rome, Atlanta and all intermediate points.''[39] By August, 1862, Stout thus found himself head of over half a dozen hospitals with a total of some 5,800 beds.

Stout met the challenge of this increased responsibility with his characteristic efficiency and stress on discipline. By November, he wrote, ''I have the hospitals in the district in good working order, receive daily reports from them which I consolidate for the Commander of this district, and in all my acts have endeavored to be guarded by the orders of the Medical Director.''[40] This is not to say that Stout did not have his problems. Particularly annoying was the situation at the hospital atop Lookout Mountain. There were complaints that the guards were inefficient, that some of the patients ''evacuated their bowels within a few paces of the sinks,'' and that others abused water privileges. Some also precipitated ''large stones from the mountain upon the men working at the pumps below thereby endangering their [the workmen's] lives.''[41] As one solution, Stout requested more guards. A shortage of guards was also a problem at the other hospitals. In September, 1862, he wrote headquarters that ''unless an efficient guard of at least thirty men under a command officer is furnished (for the Academy Hospital alone) it is utterly impossible to protect the sick, prevent desertion, and avoid the purloining of valuable property.''[42] Stout got his men.

In general, however, things ran quite smoothly. Stout made every effort to maintain order among the hospitals and to prevent overcrowding. He attempted to keep vacant between 100 and 150 beds each day in the Chattanooga area to receive the newly wounded, transferring the convalescents to hospitals further south as far as Atlanta. Likewise, the Superintendent tried to spread the load evenly among the hospitals in the area. In January, 1863, for example, a letter from the Foard Hospital (a recent addition to the Chattanooga number) reported that they needed some relief — their nurses were exhausted, and their surgeons tired and sick. The Academy thus detailed some assistant surgeons to give aid.[43]

In the more smoothly running routine of Chattanooga, Stout seems to have modified his views on the helpfulness of women to the medical service. As reported by Kate Cumming, who visited Stout the month he was made Superintendent:

> *I went to Chattanooga and called upon Dr. Stout, the chief post surgeon of Bragg's army, who received me very kindly. He complimented the ladies for what they were doing in the good cause and said no hospital was complete without them. I told him I was surprised to hear him speak thus, as I had been told he did not approve of ladies in that capacity. He said he knew how he got that name. While in charge of hospitals in Nashville, the ladies had interfered with him so much, he had to forbid their coming; but when they attended to their own duties, and not the doctor's, there was no end to the good they could accomplish.*[44]

Stout's positive attitude to the activities of the ladies, as long as they kept their place, is also reflected in his own reminiscences.[45]

In the spring of 1863, 9 months after Stout had been made Superintendent, the medical service of the Confederate Army was restructured. Up to this point, Stout had been reporting to Dr. A. S. Foard,[46] the Medical Director of the Army of Tennessee, who in turn was responsible to the Surgeon General, S. P. Moore in Richmond. Though Stout was responsible to Foard, he had more or less a free hand in running the hospitals, as Foard's major responsibility lay with medical service in the field. According to Stout, it was the ''happy working of this policy [that] recognized the importance of divorcing the direct control of the hospitals from that of medical direction of armies in the field [that suggested] the appointment by the War Department of [the new position] of Medical Director of Hospitals.'' Thus, Stout felt, ''it is to [Bragg] the credit of that new departure in the organization and management of hospitals is due. The Surgeon General had never thought of it before.''[47]

Much to Stout's chagrin, however, the War Department appointed him Inspector of Hospitals rather

than Medical Director. On May 20, 1863, an annoyed Stout wrote to a colleague:

> *I have received this day an order from the Sec. of War assigning me to duty as "Inspector of Hospitals of Gen. Bragg's armies." I have not and will not acknowledge the receipt thereof until I hear from you. If the office is the same "contemptible sinecure" which it has heretofore been and been regarded by the army I cannot and will not accept it. . . . If the "Inspectorship" gives me the powers of Supt., and does not place another between me and Gen. Bragg's Med. Director, I will accept it, but I will not serve in the medical department superseded by Dr. Pim or anyone else, in the relative position I now occupy.*[48]

Stout's wish for the Directorship got the strong backing of Bragg. "I think I can safely assure you that General Bragg will have justice done you," wrote a fellow surgeon. "His manner in expressing a preference for you was most decided and emphatic. 'I had rather have him appointed than any man in my department' were his words. You have not only given satisfaction, but to you, in great measure, is due the present good condition of the hospital," added the surgeon in encouragement.[49] By June, Stout's supporters had prevailed at headquarters; he was appointed Medical Director of Hospitals for the Department and Army of Tennessee. Final credit for Stout's victory may belong, however, to Foard's initiative rather than to Bragg's. "For the work you did," wrote Foard to Stout in 1866, "I claim much credit for myself in the selection of the man most fitted for the position you occupied — you may not have known the extent of my power but with my General with whom I served my recommendation for an assignment was an order."[50]

Footnotes

1. Cunningham HH. Doctors in gray. Baton Rouge: Louisiana State University Press, 1958.
2. Breedon JO. Joseph Jones M.D.: scientist of the old south. Lexington: University Press of Kentucky, 1975.
3. Hale WT, Merritt D. A history of Tennessee and Tennesseans. Chicago: Lewis, 1913, II, 518.
4. Stout K. Biographical sketch. Emory University, Stout, MSS., Box 1.
5. Obituary. Southern Practitioner 1903;25:210.
6. Stout SH. The facts of the history of the organization of the medical service of the confederate armies and hospitals: prefatory. St. Louis Med and Surg J 1893; 60 (Apr.):232. This was the first of a 24-item series of articles that continued in the *Southern Practitioner* 1900-1903. Henceforth, the series will be referred to as "History of the Medical Service," followed by citation.
7. Obituary. Southern Practitioner, 210. No mention could be found as to with whom Stout studied medicine at this time.
8. Stout MSS., Box 3.
9. Fleming D. William H. Welch and the rise of modern medicine. Boston: Little, Brown, and Company, 1954.
10. Ibid, p. 10.
11. Box 3. The medications written down by Stout are nearly illegible. He obviously had already mastered the art of writing prescriptions.
12. Obituary. Southern Practitioner, 210.
13. Draft of letter from Stout to Mason, March 29, 1848, Stout MSS., Box 1.
14. Obituary. Texas Med J 1903; 19:128.
15. Stout K. Biography.
16. Stout SH. History of the medical service: prefatory. 232-3.
17. History of the medical service. Southern Practitioner 1901; 23 (Feb):101. This was not at all rare among rural troops either North or South. Cunningham remarks that in a camp near Raleigh, NC, some 4,000 troops caught the disease out of a total of 10,000 men, while in the Army of the Potomac, over 8,000 cases were reported during a 3-month period in 1861. p. 188.
18. Ibid 1901; (Apr.):149.
19. Ibid 1900; (Nov.):227.
20. Ibid 1901; (May):193.
21. Ibid, 227.
22. Ibid 1902; 24 (Jan.):50; Ibid 1900; 23 (Nov.):227.
23. Cunningham, p. 45.
24. Yandell (1826-1898) received his M.D. from the University of Louisville in 1846 and then studied two years in Europe. At the outbreak of the war, he held the chair of clinical medicine at Louisville. A. S. Foard replaced Yandell as Director in 1862, and Yandell went on to hold other important positions. After the war, Yandell resumed his eminent teaching career at Louisville. He was president of the AMA in 1871 and also helped establish the important *American Practitioner* in 1870.
25. Draft of letter to Yandell, December 19, 1861, Stout MSS., Box 1.
26. Stout SH. History of the medical service. Southern Practitioner 1902; 24 (Mar.):161.
27. There were 650 patients in the hospital when Stout first arrived. They were sprawling on bunks and the floor. Most had the measles or the "sequela thereof" and many were quite sick. Idem.
28. Idem.
29. Ibid 1903; 25 (Jan.): 27.
30. Ibid 1902; (Apr.):213.
31. Draft of circular, written December 10, 1862, Stout MSS., Box 1.
32. Stout SH. History of the medical service. Southern Practitioner 1903; 25 (Mar.):158.
33. Ibid 1902; 24 (Nov.):624.
34. Idem.
35. The hospital was named after Mrs. Ella King Newsom, who had begun her famous hospital work at Bowling Green. Cunningham, p. 46.
36. After General Johnson's death, the Department of the West was split in two. Bragg was given command of the Department and the Army of Tennessee.
37. Stout SH. History of the medical service. Southern Practitioner 1903; 25 (Feb.):93.
38. Stout SH. Outline of the organization of the medical department of the Confederate Army and Department of Tennessee, especially the hospitals. Photocopy in Stout MSS., Box 3. p. 19-20. Henceforth referred to as "Outline of the Medical Department."
39. Draft of Special Order No. 81, Part XII, July, 1862, Stout MSS., Box 1.
40. Draft of letter to unnamed person, November 7, 1862, Stout MSS., Box 1.
41. Byrle (?) to Stout, August 1, 1862, Stout MSS., Box 1.
42. Draft of letter to Pyton, September 1, 1862, Stout MSS., Box 1.
43. Hamilton to Stout, January 5, 1863, Stout MSS., Box 1.
44. Cumming K. Gleanings from southland. Birmingham: Roberts and Son, 1895.
45. For example see Stout SH. History of the medical service. Southern Practitioner 1903; 25 (Sept.):523.
46. Foard (1827-1868), a native of Milledgeville, received his M.D. from Jefferson Medical College, Philadelphia. He held a commission as assistant surgeon in the United States Army for about nine years before the war broke out. Thus he too was familiar with regulations. He died in 1868, at the age of 39, shortly following his appointment to the Chair of Anatomy at Washington University, Baltimore.
47. Stout SH. History of the medical service. Southern Practitioner 1903; 25 (May):279.
48. Draft of letter Stout to Flewellen, May 20, 1863, Stout MSS., Box 1.
49. Gamble to Stout, May 6, 1863, Stout MSS., Box 1.
50. Foard to Stout, September 25, 1866, Stout MSS., Box 4. Photocopy.

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered, isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc.
Manati, Puerto Rico 00701

Motrin® vs codeine...

ibuprofen



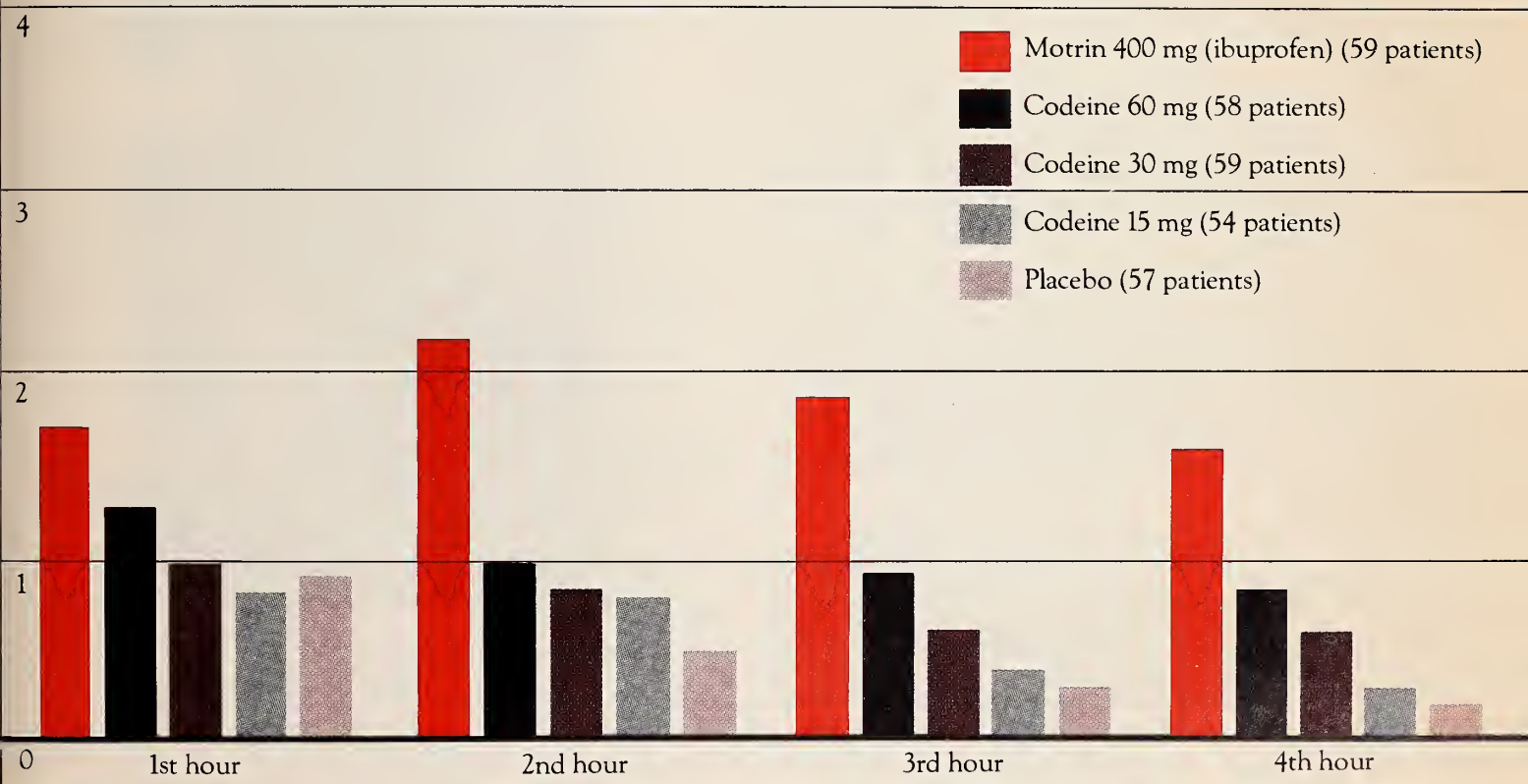
© 1980 The Upjohn Company

compare the analgesic effect

Motrin (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients. *Motrin* was significantly more effective ($p < 0.01$) than codeine 60 mg at the 2-, 3- and 4-hour intervals...significantly more effective ($p < 0.01$) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

Degree of pain relief—mean scores

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



Data on file at The Upjohn Company.

One tablet q4-6h prn pain

A well-tolerated, nonnarcotic prescription for mild to moderate pain

Motrin® 400 mg TABLETS

ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Acts peripherally
- Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
- The most common side effect with *Motrin* is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

MED B-4-S

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

J-7835-4

May 1980

It's hard to decide who needs your gift the most, isn't it?



United Way helps you do the right thing.

You give so generously. And yet, you can't help wondering if you're helping all the people you can.

When you give through United Way, you support a wide range of human services. Needs and distribution of funds are reviewed by local volunteers. People like you who visit agencies, go over budgets, check for duplication.

All to make sure your one generous gift does all you want it to do.

Thanks to you, it works. For all of us.

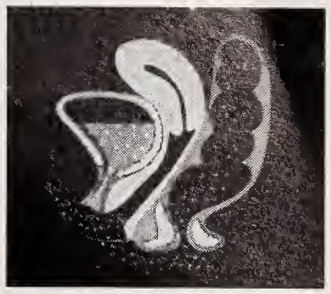
United Way

Ad A Public Service of This Magazine & The Advertising Council

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets



Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

The author describes an interesting coincidence found at autopsy.

Multiple Endocrine Neoplasia Involving Steroid Producing Glands

KENNETH ALONSO, M.D., *Stockbridge**

Multiple endocrine neoplasia is thought to involve only peptide secreting endocrine glands.[1] Abnormalities of steroid secreting endocrine glands are unusual and thought to be secondary to ectopic hormone production of the peptide secreting endocrine glands.[2] Gonadal lesions are rarely described with multiple endocrine neoplasia.[3] When steroid secreting endocrine gland abnormalities are seen, they are generally grouped with those lesions comprising Type I. The following case report describes multiple endocrine gland and gonadal involvement noted incidentally at postmortem examination.

Case Report

The patient was a 76-year-old black man with known hypertensive myocardiopathy maintained on digoxin and a diuretic. Following 1 week of ibupofren therapy for back pain, he presented with congestive heart failure, manifesting atrial fibrillation with a slow ventricular response. Blood pressure was 116/74. The ventricular rate was raised with isuprel. Digoxin was discontinued, and procainamide was started. The cardiac problems resolved, but pneumonia and sepsis subsequently developed. The patient was started on a combination of a cephalosporin and gentamycin. *Klebsiella pneumoniae* was isolated and was sensitive to the antimicrobials employed. After six days of antimicrobial therapy, the patient experienced oliguric renal failure (serum creatinine to 8.8 mg/dl). Prior to the onset of renal failure serum glucose; serum calcium and the chloride/phosphorous ratio; serum potassium and total carbon dioxide; thyroxine and thyroid binding proteins were all normal. The patient died during peritoneal dialysis.

Postmortem examination confirmed the presence of cardiomegaly and concentric left ventricular hypertrophy. The renal tubules were dilated and contained acellular eosinophilic material centrally located. Tubular basement membranes were thickened. The changes were compatible with those described for tubular injury following cephalosporin-aminoglycoside use. Endocrine abnormalities included a follicular adenoma of the thyroid gland, an adrenal gland carcinoma 1 cm in diameter (right), and bilateral extensive interstitial cell hyperplasia of the testes. No pituitary lesion was identified.

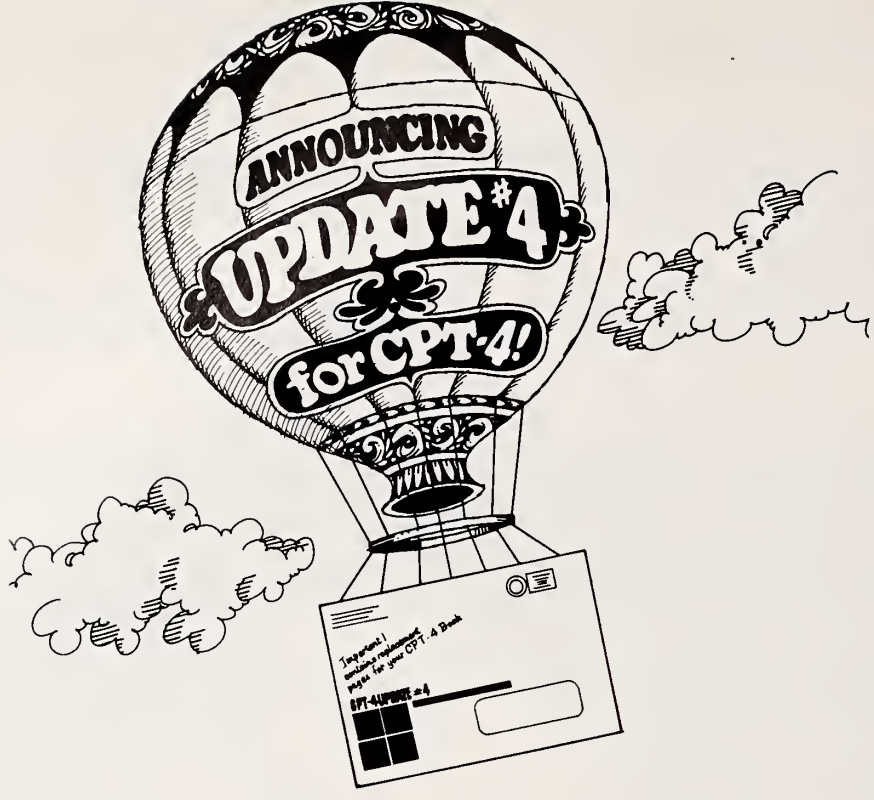
Discussion

The combination of adrenal and testicular abnormalties in the absence of pituitary involvement strongly suggests ectopic peptide hormone production as the stimulus for the morphologic abnormalities noted. It is unlikely prostaglandin inhibition or cephalosporin-aminoglycoside use were responsible for the constellation of abnormalities found.

References

1. Weichert RF. The neural ectodermal origin of the peptide secreting endocrine glands. Am J Med 1970; 49:232-241.
2. Schimke RN. Multiple endocrine adenomatosis syndromes. Adv Int Med 1976; 21:249-265.
3. Ballard HS, Fame B, and Hartsock RJ. Familial multiple endocrine adenoma-peptic ulcer complex. Medicine 1964; 43:488-516.

* Dr. Alonso practices pathology. Send reprint requests to him at Henry General Hospital, 1133 Hudson Bridge Rd., Stockbridge, GA 30281.



That's what keeps CPT-4 the most current medical reporting system you can use!

The 4th Edition of *Physicians'* CURRENT PROCEDURAL TERMINOLOGY is the only coding system that provides new and revised terminology on a regular, automatic basis. This latest update, Summer 1980 marks the fourth update since CPT-4 was published in 1977.

The updates are on self-adhering pages that are affixed to the pages they replace in CPT-4. To activate the update mechanism, you simply return the postage-free card in the book.

CPT-4 is a uniform coding system to accurately designate medical, diagnostic, and surgical services in terms of a uniform language among physicians, patients, and third parties.

Shouldn't you be using the most current coding system available?

Order two—one for yourself, one for your medical records clerk.

For information about CPT-4 in computer tape format, write: Dept. of Applied Medical Systems, AMA, 535 N. Dearborn, Chicago, IL 60610.

Order Dept., OP-41
American Medical Association
P.O. Box 821
Monroe, Wisconsin 53566

SJ

Please send me_____ copy(ies) of *Physicians* Current Procedural Terminology, 4th Edition, OP-41. Price: $12 per copy. Enclosed is my check (payable to AMA) for $_____. Allow 4-5 weeks for delivery.

Name _____

Address_____

City/State/Zip _____

Marijuana For Nausea and Vomiting in Cancer Patients

Nausea and vomiting are common side effects to chemotherapy and radiation therapy used in the treatment of cancer. Frequently, these symptoms produce physical and emotional debility which compromise the patient's ability to take cancer treatment. Antiemetics play a major role in the treatment of nausea and vomiting, but in some patients they are ineffective in controlling these symptoms. In an attempt to find new and more effective antiemetic drugs, several investigators have recently reported that Delta-9-Tetrahydrocannibol (THC) can abort the nausea and vomiting induced by chemotherapy.[1-4] It has been demonstrated that THC taken orally causes the same physiologic effects as smoking marijuana.

Sallan, *et al*[1] reported that 30% of the patients taking THC in association with chemotherapy experienced no vomiting, and 45% had a significant reduction of their vomiting. The same group of patients were also given a placebo, and none of the patients experienced any benefit. A total of 81% of the patients experienced a "high" characterized by mood changes, i.e. laughing, elation, and aberration of fine motor coordination. There were no reports of delayed effects or hangover. Somnolence occurred in ⅔ of the group, and 10% experienced paranoid ideation, visual hallucinations, and depression. Subsequently, several reports have been published in an attempt to confirm Sallan's findings, and the majority of these have been favorable. A synthetic cannabinoid, Nabilone, has been shown to be more effective than prochloperazine (Compazine) in alleviating vomiting.[2] Eighty percent of patients receiving Nabilone experienced significant reduction of their vomiting. Although many of the patients experienced somnolence, light headedness, and euphoria, most patients preferred Nabilone over Compazine. In spite of its effectiveness, the drug has been withdrawn from further human use because of several cases of unexplained deaths in long-term animal experiments.

Chang, *et al*[3] reported benefit in 90% of patients with osteogenic sarcoma receiving high-dose Methotrexate and THC. Likewise, Lucas[4] published a recent report of 52 patients with a variety of tumors who experienced marked reduction of vomiting when premedicated with THC. All of his patients were refractory to standard antiemetics prior to exposure to the marijuana derivative.

In a somewhat conflicting report, the Mayo Clinic concluded that THC was better than placebo but offered no advantage over Compazine.[5] In their group of 116 patients, most of whom were elderly, they observed significant central nervous system (CNS) toxicity in 32%. The toxicity included ataxia, hypotension, visual hallucinations, and altered thinking.

Despite the evidence that THC has a beneficial antiemetic effect, several problems need to be resolved. The drug appears to be absorbed erratically when given by mouth. There is wide variability in absorption and peak serum levels from patient to patient and even in the same patient when measured serially. Elderly patients appeared to be more prone to the serious CNS side effects than younger patients.

Finally, THC does not appear to be uniformly effective against all chemotherapy drugs. Cis-Platinum, which induces significant nausea and vomiting in almost all patients, appears to be resistant to the antiemetic effect of THC.

The problem of nausea and vomiting in association with cancer chemotherapy is a difficult and complicated one. Many factors appear to contribute to these symptoms, including the type of drug used, the nature of the underlying malignancy, the physical setting in which chemotherapy is administered, as well as the patient's subjective attitude about the effectiveness of therapy and any preconceived ideas he or she may have regarding cancer chemotherapy. Our personal experience has been that most patients receiving cancer chemotherapy can be treated effectively with minimal nausea and vomiting by a team of compassionate and understanding personnel. In spite of this, we have observed some patients in whom nausea and vomiting produce significant debility which compromises the effectiveness of the treatment. Several of these patients have voluntarily experimented with marijuana and reported moderate relief of their symptoms. Because of this observation, as well as the findings of several investigators, we feel that marijuana or one of its chemical derivatives will eventually find a place in the armamentarium of the physician treating cancer patients.

Stanley H. Winokur, M.D.
J. Jay Baker, M.D.
Julian L. Lokey, M.D., and
Norma A. Price, M.D.
Georgia Oncology Hematology Clinic
Atlanta, GA

References

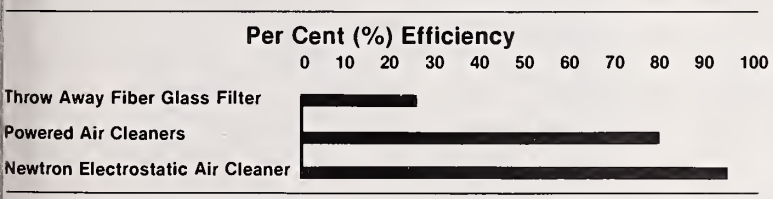
1. Sallan SE, Zinberg NE, Frei E. Antiemetic effect of Delta-9-Tetrahydrocannabinol in patients receiving cancer chemotherapy. N Engl J Med 1975;293:795-797.
2. Herman TS, Einhorn LH, Jones SE. Superiority of Nabilone over Prochlorperazine as an antiemetic in patients receiving cancer chemotherapy. N Engl J Med 1979;300:1295-1297.
3. Chang AE, Shling DJ, Stillman RC, Goldberg NH, Seipp CA, Barofsky I, Simon RM, Rosenberg SA. Delta-9-Tetrahydrocannabinol as an antiemetic in cancer patients receiving high dose methotrexate. Ann Int Med 1979;91: 819-824.
4. Lucas VS, Laszio J. Δ-9-Tetrahydrocannabinol for refractory vomiting induced by cancer chemotherapy. JAMA 1980;243:1241-1243.
5. Frytak S, Moertel CG, O'Fallon JR, Rubin J, Creagan ET, O'Connell MJ, Schutt AJ, Schwartau NW. Delta-9-Tetrahydrocannabinol as an antiemetic for patients receiving cancer chemotherapy. Ann Int Med 1979;91:825-830.

Doctor, your patients will be asking about the Newtron® Electrostatic Air Cleaner.



And with good reason. The Newtron® electrostatic air cleaner is a revolutionary new device that allows allergy patients to breathe clean air in their homes and offices — at a much lower cost than has ever been possible before.

In fact, the Newtron® is the only reasonable answer to the problems caused by pollen, dust, smoke, and other air pollutants. It requires no electricity, never needs to be replaced, requires no maintenance other than a monthly rinsing with tap water, and comes in standard filter sizes to simply replace the existing throw-away filter in heating and air conditioning systems. Even more importantly, it far out-performs all other cleaners, including electrically powered models costing more than three times as much.



In the past, high costs and complicated installation have put truly clean air out of the reach of most allergy patients. Now that the Newtron® is available — and has been proven effective in hospitals, businesses, private homes, and apartments — your patients will be asking for your approval or opinion.

Please allow us to send you a complete information package on the Newtron®. No salesman will call, either in person or by telephone (unless you request it). The price of the Newtron® varies from $195 to $205, according to size. (Master Charge® and VISA® are accepted.) Professional discounts on Newtron® electrostatic air cleaners are available to physicians who wish to purchase one unit for their personal use.

Newtron®

The ultimate air cleaner.

Clip and mail this coupon to

Newtron Sales
202 Nottingham Ln.
Slidell, La. 70458

Please send complete information on the Newtron® electrostatic air cleaner.

Dr. _____

Address _____

City _____ State: _____

Zip: _____

Specialty: _____

Newtron® is a registered trademark of Newtron Products Co., Cincinnati, Ohio
The generic name is electrostatic air cleaner

Peachford Hospital

A uniquely positive, comprehensi

Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.



CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. Patients are completely drug free prior to discharge. Twenty-four hour admittance is offered for all programs.



MEDICAL SERVICE DIRECTORS

BOAZ HARRIS, M.D.
Medical Director

CONWAY HUNTER, JR., M.D.
Director, Addictive Disease Unit

CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

JOHN B. HARDMAN, M.D.
Director, Children's Unit

ogram of recovery...that's working!



The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

plete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30338
Phone (404) 455-3200



heart page
heart page
heart page

Hypertension: Morbidity, Treatment, and Compliance

ARTHUR J. MERRILL, JR., M.D., *Atlanta**

A PERSON WITH HYPERTENSION has a significantly increased risk of morbidity and mortality. If a man's blood pressure is greater than 150 systolic or 100 diastolic, his risk of stroke, congestive heart failure, and coronary disease is increased 5×, 4×, and 2.5×, respectively. Almost the same risk ratio applies to women.[1] This increased risk holds for all increases in blood pressure, no matter how little. A recent study by the Society of Actuaries and the Association of Life Insurance Medical Directors found a 36% increase in mortality for men with a systolic pressure of 138-147 mmHg who were not treated, and a 38% increase in mortality for those not treated with diastolic pressure in the range of 88-92 mmHg.[2] Patients with blood pressures in these systolic and diastolic ranges after treatment had only a 13% and 24% excess mortality. Treatment, even with incomplete control of blood pressure, lowers mortality.[2, 3]

Effect of Treatment

Lowering blood pressure to within normal limits in patients with moderate or severe hypertension was shown 10 years ago to reduce morbidity and mortality significantly.[4-6] Should we treat patients with mild hypertension (diastolic pressures 90-104)? A recently published study has answered this question with a resounding yes.[7] Not only should we treat them, it is essential that we lower their blood pressure to within normal limits. This study compared outcomes in patients treated by their own physicians (Referred Care = RC) with those treated in a clinic where the goal of treatment was to lower diastolic pressures to 85-90 mmHg (Stepped Care = SC). Results showed the 5-year mortality was 17% lower in the SC group, mortality from myocardial infarction was 26% less, and from cerebrovascular diseases 45% less. These differences in mortality appear to be due to the SC's group setting and reaching normal blood pressure "goals" in contrast to the RC group which set no such "goals." Clearly, we must be more aggressive in our treatment of all blood pressure — striving for a goal of less than 90 diastolic.

Method of Treatment

Once the goal of therapy is set at lowering diastolic pressure to less than 90 mmHg, the goal can be achieved in many ways. Weight reduction and salt restriction can be expected to lower blood pressure, often dramatically. In one

* Dr. Merrill is Director, Cardiac Catheterization Lab, Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta, GA 30309. Send reprint requests to him. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis A. Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

study,[9] hypertensive patients carefully followed on a weight reduction program without salt restriction lost an average of 9.8 kg; their blood pressures fell by an average of 37.4/23.3 mmHg. Seventy-five percent of the obese hypertensives experienced a return to normal blood pressures after weight loss alone. Salt restriction has been shown to be equally effective in lowering blood pressure. Salt intake can be lowered from the usual 150-200 mEq of sodium per day to 75 mEq by avoiding salty foods and leaving salt off the table and out of cooking.

All hypertension, no matter how minimal, needs to be treated, with the goal being a blood pressure less than 90 diastolic.

A Mayo Clinic study[10] (uncontrolled) demonstrated that lowering sodium intake to 75 mEq/day resulted in diastolics below 90 in 85%, 63%, and 51% of patients with mild (90-104 mmHg diastolic), moderate (105-114 mmHg), and severe (diastolic $\geq$ 115 mmHg) hypertension, respectively. Stopping smoking and reducing caffeine intake also helps to lower blood pressure. If blood pressure control is not achieved by these measures, then diuretics (step 1) and antihypertensives (beta blockers, clonidine, methyl dopa, reserpine, hydralazine, prazosin) (step 2) will usually bring blood pressure down to below 90 diastolic — the goal we must strive for.

Compliance Problems

Why can't we control patients' blood pressures by salt restriction, weight loss, and even often by drugs? Two thirds of our patients do not follow our advice and take the medications we prescribe "sometimes or infrequently or never." This poor compliance can be improved by close patient follow-up — initially every 2 weeks — and explanations to the patient about hypertension, its causes (e.g. excess salt, obesity), what can happen to him, and what he must do to get well. These explanations may need to be repeated on subsequent visits, either by us or our nurse.

Recommendations should be kept to a minimum and usually be in writing, including medication names and frequency of doses. With medications or diet, visual cues such as a note on the refrigerator door may remind a patient. Record keeping by the patient of medications, content of meals, and exercise is helpful and serves two purposes: (1) it cues the correct action by the patient, and writing this down is a small reward for correct behavior; (2) review of these records with the patient at the next visit allows the physician to praise appropriate action and pinpoint problems. Pill counts and 24-hour urine sodiums are sometimes necessary to check compliance. More often a periodic call from us or our office nurse is all that is needed to reinforce medication use and check for side effects that decrease compliance.

Adequate training in dietary instruction for physicians and their nurses will also aid in weight loss and adequate sodium restriction for patients. (In one study, there was a 5 kg loss over 6 months vs. 1.9 kg loss if doctors didn't have special instruction.) The sum of all of the above techniques is that they indicate that we care about our patients — this is probably the most important thing of all. If our patients respect us and feel we are concerned about them, they are more likely to follow our instructions.

Summary

(1) All hypertension needs to be treated, with the goal being a blood pressure less than 90 diastolic.

(2) A large percentage of hypertensive patients can be effectively treated with weight loss and salt restriction alone, but compliance requires frequent follow-up and education.

(3) Most others can be effectively treated with a diuretic or mild step 2 therapy.

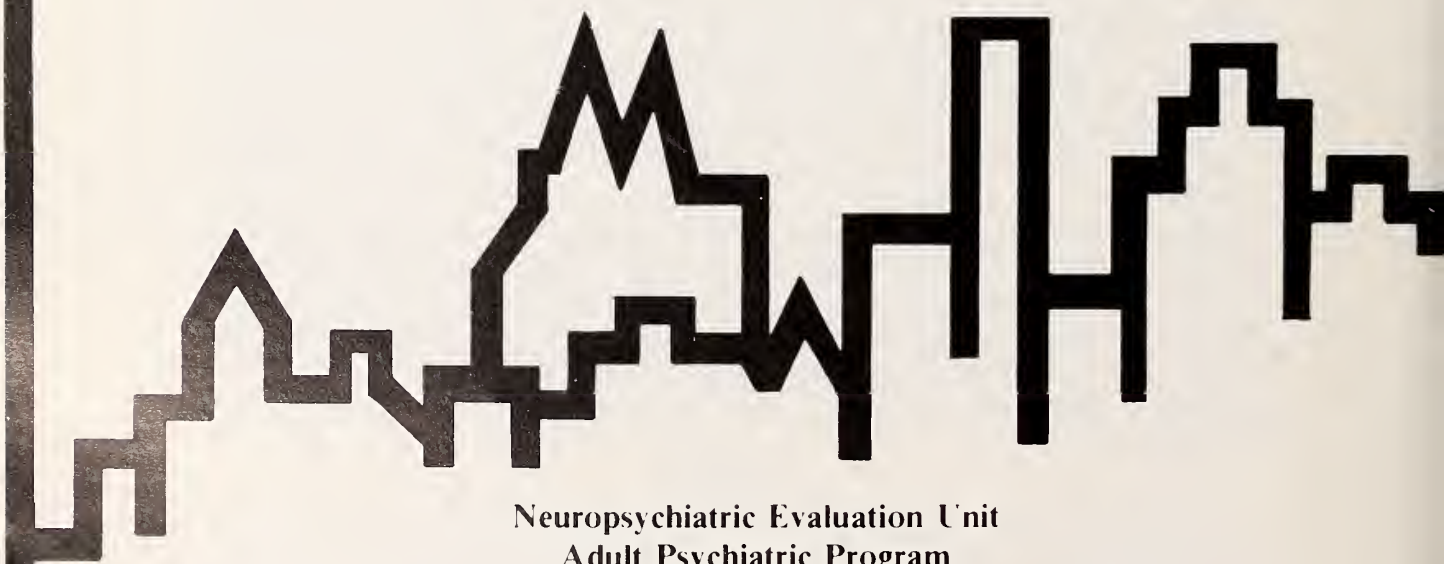
(4) Patient compliance is not good in two-thirds of patients but can be improved significantly by the methods above, plus close follow-up in the office and by phone.

References

1. Kannell WB. Role of blood pressure in cardiovascular morbidity and mortality. Prog Cardiovascular Dis 1974;17:5-24.
2. Society of Actuaries and the Association of Life Insurance Medical Directors. Build and blood pressure study 1979. Quoted in Int Med News 1980;1.
3. Taquchi J, Fried E. Partial reduction of blood pressure and prevention of complications in hypertension. N Engl J Med 1974;291:329-331.
4. VA cooperative study group on anti-hypertensive agents. Effects of treatment of morbidity. I. Patients with diastolic blood pressures of 115-129 mmHg. JAMA 1967;202:1028-1034.
5. Idem, Effects of treatment on morbidity in hypertension. II. Patients with diastolic blood pressures 90-114 mmHg.
6. Idem, Effects of treatment on morbidity in hypertension. III. Influences of age, diastolic pressure and prior cardiovascular disease; further analyses of side effects. Circulation 1972;45:991-1004.
7. Five-year findings of the hypertension detection and follow-up program. I. Reduction in mortality of persons with high blood pressure, including mild hypertension. JAMA 1979;242:2562-2571.
8. Idem, II. Mortality by race, sex, and age. JAMA 1979;242:2572-2577.
9. Reisner, et al. Effect of weight loss without salt restriction on the reduction of blood pressure in overweight hypertensive patients. N Engl J Med 1978;298:1-6.
10. "Salt Reduction and Blood Pressure Control," in *Hypertension Update: Mechanisms, Epidemiology, Evaluation, and Management*. (ed.) J. C. Hunt. Health Learning Systems, Inc., 1980. pp. 197-208.
11. Taylor RB. Patient compliance incentives that work. Physicians Management 1980;76-81.
12. Silverberg DS. Treating hypertension with diet. Consultant: 1980;116.

Psychiatric Institute of Atlanta

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

Great Investment
With A Beautiful Return

Oriental rugs from far and middle east have proven to be an excellent hedge against inflation; while adding beauty to your home or office.

House of Persia has been for 17 years, the source in Atlanta for fine oriental rugs. See our tremendous inventory of originals and start enjoying the security of an investment with a beautiful return.

house of persia

Next to Brennans in Buckhead
107 West Paces Ferry Road
Phone 266-8458
Hours Mon.-Sat. 9:30 A.M.-6:00 P.M.

THE BMW 633CSi
CONCLUSIVE PROOF THAT THE THRILL OF DRIVING IS NOT YET EXTINCT.

Faced with an unceasing barrage of performance-sapping safety rules and pollution regulations, more than one automotive expert has speculated that automotive performance may soon only be achieved "with decals and racing stripes..."

Yet if the genius of BMW engineering is evident anywhere, it is in managing to meet all the demands of society and still build the 633CSi. A six-cylinder masterpiece of engineering that will have you seeking out winding back roads and long sweeping curves.

If the thought of owning such a high-performance driving machine intrigues you, contact your nearest BMW dealer to arrange a test drive.



THE ULTIMATE DRIVING MACHINE.
BMW, MUNICH, GERMANY

© 1979 BMW of North America, Inc. The BMW trademark and logo are registered trademarks of Bayerische Motoren Werke, A.G.

GLOBAL IMPORTS

225 PHARR ROAD, N.E. / ATLANTA, GEORGIA 30305 / TELEPHONE: (404) 261-9730



Tail of whipworm
(Trichuris trichiura)

Vermox®: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX®	68%*	93%**
Mintezol[1]	35%†	45%††
Antiminth[2]	Not Indicated	
Povan[3]	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.®

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS (mebendazole)

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

© Janssen Pharmaceutica Inc. 1980

JPI-023



Broad-spectrum coverage in mixed helminthic infections

Vermox® TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX® in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX® in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.

JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

NUTRITION SERVICES CENTER

NUTRITION · SERVICES · CENTER
Emory University
SCHOOL OF MEDICINE

PHYSICIAN REFERRAL

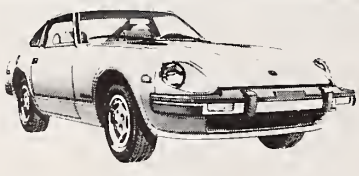
- Computerized Nutrition Analysis
- Diet Therapy by Clinical Nutrition Specialists
- Hospital Consults

Nutrition Services Center
Emory University School of Medicine
1712 Clifton Road
Atlanta, Georgia 30329
Telephone (404) 329-5737

LEASE A 1981

280 ZX ONLY $240.00

200 SX 40 mpg	$155	510	$158
210 51 mpg	$124	810 Maxima	$248
310 43 mpg	$139	BMW	$325



CALL
Gary Mack
455-1122

FOR DAILY RENTAL INFORMATION
CALL MIKE THOMPSON

HICKMAN DATSUN
5211 Peachtree Industrial Blvd.

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING


COUGH
COUGH
COUGH

For Sneezing and Nasal Congestion



RU-TUSS® TABLETS

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

- Vasoconstrictor, antihistaminic actions
- Rapid and prolonged relief of nasal and sinus congestion
- Convenient b.i.d. dosage

Boots Pharmaceuticals, Inc.
Pioneers in Medicine

For Coughing With Nasal and Bronchial Congestion



RU-TUSS® EXPECTORANT

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate (WARNING: MAY BE HABIT FORMING)	65.8 mg
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

- Vasoconstrictor, antihistaminic, expectorant actions with codeine
- Rapid relief of upper respiratory congestion and cough
- Good tasting

eveport, Louisiana 71106.
the Family

SNEEZE

RU-TUSS® TABLETS

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings:).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
Bottles of 500 Tablets	NDC 0524-0058-05

Federal law prohibits dispensing without prescription.

COUGH

RU-TUSS® EXPECTORANT

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the potient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED

Pint bottles (16 fl. oz.)	NDC 0524-1010-16

Federal law prohibits dispensing without prescription.

DISTRIBUTED BY:
Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

MANUFACTURED BY:
Vitarine Company, Inc.
Springfield Gardens, New York 11413

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

Pioneers in Medicine For the Family

Investment Via Limited Partnership: Limited Deductions, Limited Liability, Limited Control

WILLIAM J. ARMSTRONG, *Atlanta**

EDITOR'S NOTE: This article is the second of two installments describing the use of limited partnerships as a vehicle for investment. The first installment, which appeared in the October, 1980, issue of the Journal, *examined in general terms the reasons for adopting the limited partnership format, as opposed to that of the standard or "Sub-Chapter S" corporation or general partnership, and also looked at the benefits accruing from the initial investment in a limited partnership. This installment describes the methods of depreciating the property, both real and personal, in which the limited partnership invests and the requirements for "recapturing" that depreciation, and also offers some tips to the limited partner on how to retain limited liability while exercising some control over important matters.*

In last month's *Legal Page,* we examined in general terms the reasons for utilizing a limited partnership as an investment vehicle. By way of example, you had been offered a chance to purchase interests in a limited partnership for $8,000.00 each. With this investment, you could participate in larger investments (such as an apartment complex) by the partnership and, through the use of non-recourse borrowing by the partnership, you could increase your tax basis and thus deduct losses exceeding your initial investment. Moreover, as you saw last month, your initial investment would be paying off "dividends" in the form of quarterly payments from the limited partnership after the payment by the latter of maintenance and operation expenses and after servicing its debt. At the same time, you also would be allocated your share of the annual "losses" of the partnership resulting from the partnership's ability to depreciate its projects.

One of the most important factors to consider in connection with investing in a limited partnership is the method of depreciation. The steeper the rate of depreciation, the greater the annual depreciation expense, the greater the losses, and the faster you will recoup your investment. The methods of depreciation which are available for this type of investment are the Straight Line method, the 125% of the Declining Balance method, the Sum of the Years-Digit method, or any other consistent method that can be shown by the taxpayer to reflect the economic facts.[1] The Component method, a mixture of the foregoing depreciation schedules, involves dividing the property into categories, such as foundations, finished carpentry, appliances, tennis courts, etc. The advantage of this method is that you can use the Straight Line method for certain categories for which accelerated depreciation is not available (e.g., personal property no longer owned by the original user), while

* Prepared at the request of the Medical Association of Georgia. Mr. Armstrong is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

at the same time using a method of accelerated depreciation on the remaining categories. A second advantage is that the cost of certain categories of assets will be depreciated over a shorter useful life rather than depreciating the entire project over the useful life of the major, durable assets (e.g., foundations — 30 years, finished carpentry — 6 years, tennis courts — 14 years, appliances — 5 years). This has the result of increasing the depreciation expense in the first years of ownership which is a desirable effect.

Recently, in response to the current recession, the Senate Finance Committee, as part of a broad tax cut program, approved useful life categories on equipment of 10 years, 7 years, 4 years, and 2 years which will have the effect of increasing depreciation by approximately 20% on these assets. The plan would allow investments in depreciable real property to be depreciated over 20 years instead of 30 to 40 years under current law. If this measure is enacted, the attractiveness of real estate investment will be significantly enhanced.[2]

The advantage to the limited partner of high annual depreciation and the resulting tax-deductible losses must be balanced against the ultimate necessity of depreciation recapture. Recapture will be triggered by either the sale of the project by the partnership or the sale by a partner of his interest in the partnership. Generally speaking, on the sale of personal property, the amount of depreciation recapture will be the lesser of the total gain on the sale or the total of all depreciation; on the sale of depreciable real property, the amount of depreciation recapture will be the greater of the gain on sale or the excess of accelerated depreciation over Straight Line depreciation.[3] The amount of recaptured depreciation will be treated as ordinary income in the year of the sale, attributable to each partner in accordance with his partnership interest. In this regard, the value of the Component method, with its use of the Straight Line method of depreciation in most asset categories, can be seen.

In summary, when considering a potential investment in a limited partnership, boasts of large deductions in the first years should be discounted by the depreciation recapture income to be incurred upon the sale of the project.

The other distinct advantage of a limited partnership is that personal liability is limited to the amount of your capital contribution. However, you must have no control over the business of the partnership, because if you attempt to do so, either by written provision in the agreement or by informal understanding, you will lose your limited liability and become generally liable for the debts of the partnership.[4] This can be great when you don't have to fix the overflowing toilet in A-5, but devastating if the general partners turn down a favorable offer to sell the project to a third party after the effects of depreciation have ceased to generate tax losses.

This last situation, refusing an offer to sell at an appropriate time, raises the question of how limited your control, as a limited partner, is. Clearly, decisions in the ordinary course of business on day-to-day affairs are beyond the influence of a limited partner. However, is the sale of the apartment project a decision in the ordinary course of business? The Uniform Limited Partnership Act does not define the term "control of the business," and the question of control has not been litigated in Georgia to date. Commentary, case law in other states, and proposed legislative reform, however, all indicate that a limited partnership agreement might provide that a limited partner could vote his interest in the partnership on the following points without being deemed to have exercised too much control: (1) the dissolution or winding up of the limited partnership; (2) the sale or other transfer of all or substantially all of the assets of the limited partnership other than in the ordinary course of business; (3) the incurrence of indebtedness by the limited partnership other than in the ordinary course of business; (4) a change in the nature of the business of the partnership; or (5) the removal of the general partner for certain acts such as breach of his fiduciary duty, violation of the partnership agreement, or self-dealing. In the revised Uniform Limited Partnership Act of 1976,[5] which has been adopted in Connecticut and Wyoming, voting rights on such issues will not result in loss of limited liability.

One final point on how you can protect your limited liability. Because limited partners are essentially silent participants in a venture and because their liability is limited to their investment in the partnership, the Uniform Limited Partnership Act requires that a certificate containing certain information be recorded in the limited partnership records maintained by the Clerk of the Superior Court for the county in which the limited partnership has its principal place of business. The theory behind this requirement is that a potential creditor of the limited partnership can ascertain from the records that he is dealing with a limited partnership, and that the liability of certain partners is limited to the amount set forth in the certificate. The creditor can then conduct himself accordingly with regard to extending credit to the limited partnership. The practical effect for you as a limited partner is that the failure to file this certificate creates a substantial risk of loss of your limited liability. Thus, after becoming a limited partner, you should verify for yourself that such a certificate has been filed.

In conclusion, a limited partnership may, in the proper circumstances, be a viable vehicle for investment. If the limited partnership documents are drafted carefully, you, as a limited partner, can have the limited liability and the tax benefits which traditionally accrue to limited partners, and, at the same time, exercise a certain measure of control over the important decisions of the limited partnership.[6]

Notes

1. Internal Revenue Code of 1954, §167, as amended.
2. The Wall St. J., Aug. 21, 1980, at 2, col. 2.
3. Internal Revenue Code of 1954, §§1245 and 1250, as amended.
4. *Ga. Code Ann.* §75-408.
5. Adopted by the National Conference of Commissioners on Uniform State Laws in August, 1976, and approved by the American Bar Association House of Delegates at the midwinter 1979 meeting.
6. This article is intended as a general overview of investment through a limited partnership and is not intended to supplant the need for specific legal advice tailored to an individual transaction.

Serving the General Insurance needs of
the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

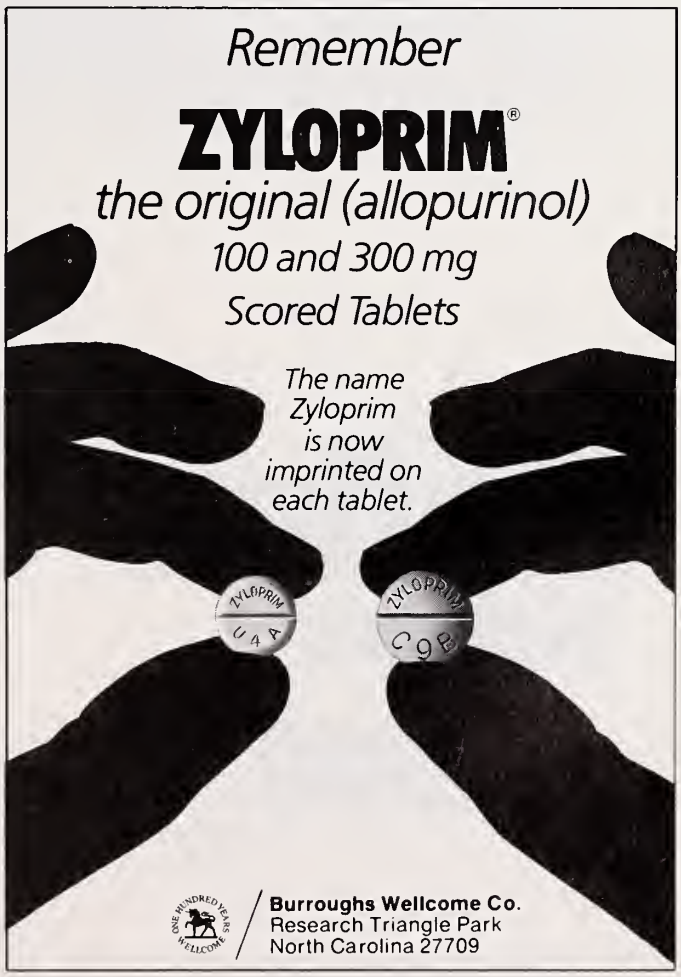
Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

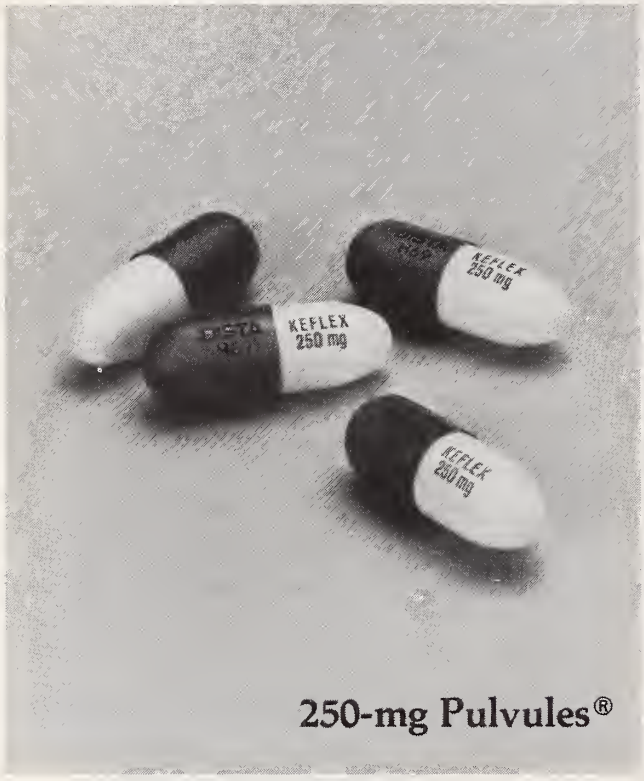
We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

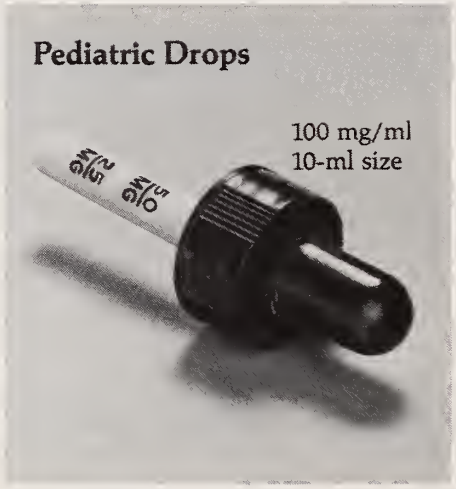
YOUR Independent Insurance AGENT



easy to take







Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

AIR ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

CHOPPER ONE



CO 101



PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO
AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

—— CALL TOLL FREE ——

GEORGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763



Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

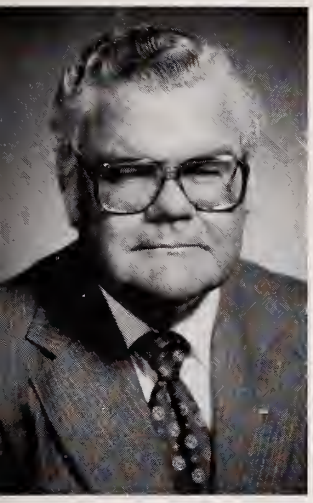
Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567



president's letter

Legislation — A Continuing Involvement

IT IS A PUZZLEMENT to me why the majority of our membership is relatively inactive in the legislative and political processes of our state and nation.

Our apathy and lack of involvement in the very process that controls our lives and our patients' interests is appalling.

MAG membership has far too long given only lip service to Jim Kaufmann, Rusty Kidd, Harrison Rogers, and a few others who, year after year, have carried the whole load.

Our Association must develop a solid, on-going, productive legislative program that involves proper planning and support, that will not fade away every year, but will become the foundation on which to build effectively and successfully.

To this goal, since September 1980, a program is being developed involving our membership in the mechanism of:

1. Support the decisions of the combined judgment of the specialty committees; the Legislative Committee; and the Executive Committee to give priority and primary concern to a unified objective of five (5) or six (6) specific legislative bills during any one General Assembly session.

This approach is absolutely necessary to avoid the divided effect of being involved in too many issues.

2. Direct mailings and telephonic communications to members, specialty societies, county and district medical societies, and key contact physicians.

3. Establishment of a "Legislative Hotline" in MAG headquarters' telephone system with messages that give the status of pending legislation of MAG concern, at any given time.

4. Increased involvement of our MAG Newsletter, Legislative Bulletin, and MAG *Journal,* in disseminating legislative information.

5. Personal visitation by MAG officers, staff, and Legislative Committee members to specialty societies and county and district societies, to both give and seek legislative advice.

6. Personal involvement of the Auxiliary, and a minimum of ten (10) MAG members in active attendance and participation during every meeting day of the General Assembly.

MAG has no reason to indulge in meekness. We must identify our values and interests.

We must retain our perspective on what we want and what we will achieve.

We must have confidence in our goals and ideals and adapt to changed conditions.

The bottom line is — SPEAK UP.

The truly effective way of obtaining quality results is direct communication between physician and legislator.

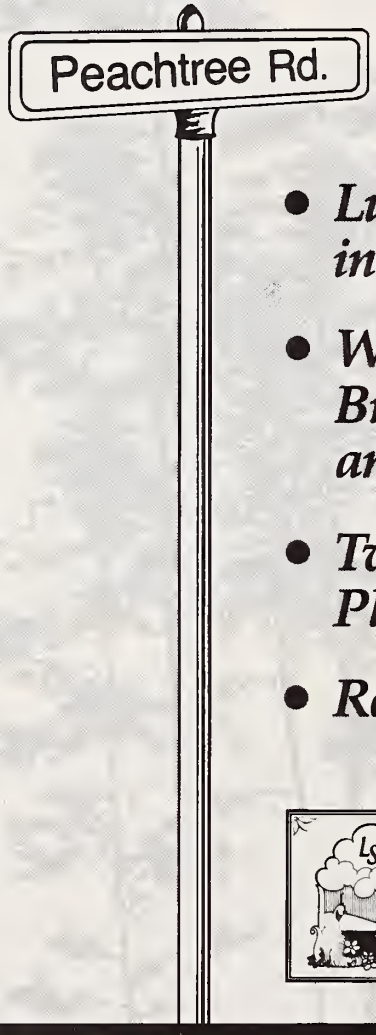
It has been said that the only thing wrong with the democratic process is our failure to use it.

I believe that says it all.

H. Hilt Hammett, Jr., M. D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

Your Retirement Residence Will Soon Be On This Street



- *Luxurious accommodations in a new 23-story building*
- *Within one mile of the Brookhaven Country Club and the Standard Club*
- *Two minutes from Phipps Plaza and Lenox Square*
- *Refundable Entrance Fee*

Lenbrook Square

Write or Call: John Pettit or Jack Clark
Lenbrook Properties • 10th Floor — Lenox Towers
Dept. ME • 3390 Peachtree Road
Atlanta, GA 30326 • 404 / 233-3000

NEW MEMBERS

Bladowski, John R., Stephens-Rabun—ACT—OTO
800 E. Doyle St., Toccoa 30577

Carter, Michael P., Ga. Med. Soc.—N-2—R
25 Wylly Ave., Savannah 31406

Chen Guey-ching Lai, Clayton-Fayette—ACT—GP
150 Medical Way, Ste. B, Riverdale 30274

Fresh, James W., Ogeechee River—ACT—GP/PTH
209 Daniel St., Millen 30442

Harries, John D., Bibb—N-2—AN
Mercer University School of Medicine, Macon 31207

Hupman, Aaron J., MAA—I&R—D
Grady Memorial Hospital, Atlanta 30303

Jhee, Thomas S., MAA—ACT—GP
549 Ashby St., SW, Atlanta 30310

Lingam, Rao N., Troup—N-2—EM
West Georgia Medical Ctr., Emergency Dept., LaGrange 30240

McKinnon, William M., MAA—N-2—OS
25 Prescott St., NE, Ste. 5439, Atlanta 30308

Safer, L. F., Dougherty—N-2—D
426 Second Ave., Albany 31701

Satcher, David, MAA—ACT—FP
830 Westview Dr., Atlanta 30314

PERSONALS

First District

Gary N. Harrison, M.D., recently opened an internal medicine practice in Statesboro.

Third District

The Perry Area Chamber of Commerce sponsored a Medical Appreciation Dinner on August 19. Among those who attended the dinner were MAG members **J. R. Arnall, M.D., Charlie Dean, M.D., J. L. Gallemore, M.D., A. G. Hendrick, M.D., Ed Strickland, M.D.,** and **H. E. Weems, M.D.**

George W. Grimes, III, M.D., has opened a family practice in Milledgeville.

Fifth District

Donald Dennis, M.D., served on the faculty at the fall scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery which was held September 27 and 28 in Anaheim, CA.

John T. Godwin, M.D., an Atlanta pathologist and nuclear medicine specialist, was installed as President of the Memorial Hospital Alumni Society in New York City.

Seventh District

Everest Whited, M.D., recently opened a family practice in Dalton.

Eighth District

Ahmed Shafik Mahayni, M.D., opened a family practice in McDonough and joined the staff of Henry County General Hospital.

Ninth District

On August 24, the Towns County Hospital and Nursing Home Authority honored **John W. Acree, M.D.,** of Hiawassee, for his 25 years of service to the community. He received a plaque at a reception given in his honor.

SOCIETIES

The **Seventh District Medical Society** held their semi-annual meeting September 24 at the Allatoona Yacht Club. Approximately 80 physicians attended with their wives. Speakers included Bob Harbin, M.D., an ophthalmologist, Randy Randle, M.D., a neurologist, Charles Nuttall, M.D., a nephrologist, and Bill Harbin, M.D., a radiologist, all from Rome. James Glenn, M.D., the new Dean at Emory University School of Medicine, was the guest speaker. His talk was on "Manpower and Money."

DEATHS

William Clyde McGeary, Jr.

William Clyde McGeary, Jr., M.D., 61, died Aug. 24, 1980. Dr. McGeary was a native of Madison who had returned to his home town to practice after receiving his training.

He was the son of Dr. William Clyde McGeary and Nell Peters McGeary. During World War II, he served in the medical corps with the U.S. Army for 3 years. Following the war, he received his M.D. degree from the University of Oklahoma Medical School and interned in surgery at Grady Hospital in Atlanta. Dr. McGeary opened his practice in 1953.

He was an active member of the Oconee Valley Medical Association, the Medical Association of Georgia, the Southern Medical Association, the American Medical

Association, and the American College of Surgeons.

Survivors include his wife and one son.

In lieu of flowers, the family has asked that those who wish to make contributions do so to Morgan Memorial Hospital for the purchase of equipment for the hospital.

Benjamin Pierce Gilbert

Benjamin Pierce Gilbert, M.D., 64, died September 9.

A native of Augusta, Dr. Gilbert graduated from the University of Georgia School of Medicine. He served his internship at the Southern Baptist Hospital in New Orleans and took his residency in pediatrics at the Henrietta Egleston Hospital for Children in Atlanta and at the Children's Medical Center in Dallas, Texas.

Dr. Gilbert served in World War II as a medical officer in the U.S. Navy. He was a member of the Hall County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was a member of the First Baptist Church of Gainesville. In 1967, he organized the Interagency Council on School Child Health to improve the health of Georgia school children.

Survivors include his wife, three daughters, one son, three brothers, three grandsons, and one granddaughter.

Memorials may be made to the American Heart Association or the Pediatric Unit of Northeast Georgia Medical Center.

James Franklin Green

James Franklin Green, M.D., 47, was killed in a car accident on September 17.

Dr. Green received his M.D. degree from the Medical College of Georgia in 1961. He served a rotating internship at the Spartanburg General Hospital in South Carolina. He was a member of the American Heart Association, the American Medical Association, the Southern Medical Association, the Medical Association of Georgia, and the Carroll-Haralson County Medical Society.

At the time of his death, Dr. Green was a general practitioner who worked out of the Villa Rica Medical Clinic in Carroll County.

James Wright Merritt, Jr.

James Wright Merritt, Jr., M.D., 59, was killed September 18 in an auto accident in Bainbridge.

Dr. Merritt was born in Colquitt, Georgia, and earned his M.D. degree at Tulane University in Louisiana. He did his rotating internship at Baptist Memorial Hospital in Memphis, Tennessee, and his rotating residency at Protestant Hospital in Nashville. He came to Georgia in 1944 as a general practitioner.

Dr. Merritt was a member of the Tri-County Medical Association, the Medical Association of Georgia, the Southern Medical Association, and the American Medical Association.

Philip VanDeventer

Philip VanDeventer, M.D., 45, died Sept. 19, 1980.

Dr. VanDeventer, a native of Niagara Falls, New York, had lived in Albany for 9 years. He was a fellow in the American College of Anesthesiology, a member of the Georgia Society of Anesthesiologists, the American Medical Association, the Medical Association of Georgia, and the Dougherty County Medical Society. He was also a veteran of the Marine Corps.

Survivors include his wife, three daughters, a son, and a sister. In lieu of flowers, memorial contributions may be made to the Albany Boys or Girls Clubs or the YMCA.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award for August, 1980.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

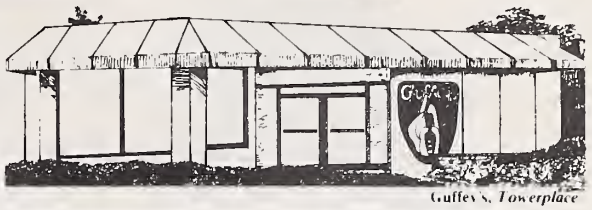
We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

M. Balasubramanian, Fort Stewart
Benjamin B. Cala, Columbus
Marvyn Donald Cohen, Columbus
Paul Victor Conesco, Decatur
George R. Conner, Columbus
Jacinto Del Mazo, Atlanta
John Green Etheridge, Macon
Ernest George Fermanis, Savannah
Louis Jack Herskowitz, Marietta
Sudershan Kumar Hooda, Dublin
William Bird Jones, Gainesville
Michael Boyd Kibble, Atlanta
Arthur Deo Klein, Hinesville
Juan Fausto Leiva, Savannah
Barry Alan Levin, Augusta
John Charles McGinnis, Savannah
A. Rafael Morales, Tucker
Jocelyn I. Robb Neufeld, Athens
F. Peter Nicholson, Riverdale
Raul Jose Pineyro, Milledgeville
Ram Kumar Puri, Dublin
Rene Ruiz, Decatur
Timothy Gerhart Saxe, Valdosta
Bernard Perry Scoggins, Albany
Curtis Lee Scribner, Atlanta
James Clarence Sikes, Macon
Simon Vasile Speriosu, Savannah
Tommy Keegan Stapleton, Douglas
Nanjappa Subramanian, Dublin
Hasan M. Turgot, Milledgeville
M. Darius Vohman, Atlanta
George Oral Waring, Atlanta

TALK IS CHEAP

in the *Journal*'s Classifieds

Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The ***Journal*'s Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.



Guffey's, *Towerplace*

Guffey's: A Tradition of Excellence

At Guffey's we belicve in the pursuit of excellence.

That's why you'll notice a special difference in the tailoring of our garments, and the quality and appearance of our fabrics.

Our employees believe in that excellence– it shows in the way you're served– and more importantly, the way we continue to serve you after your selection is made.

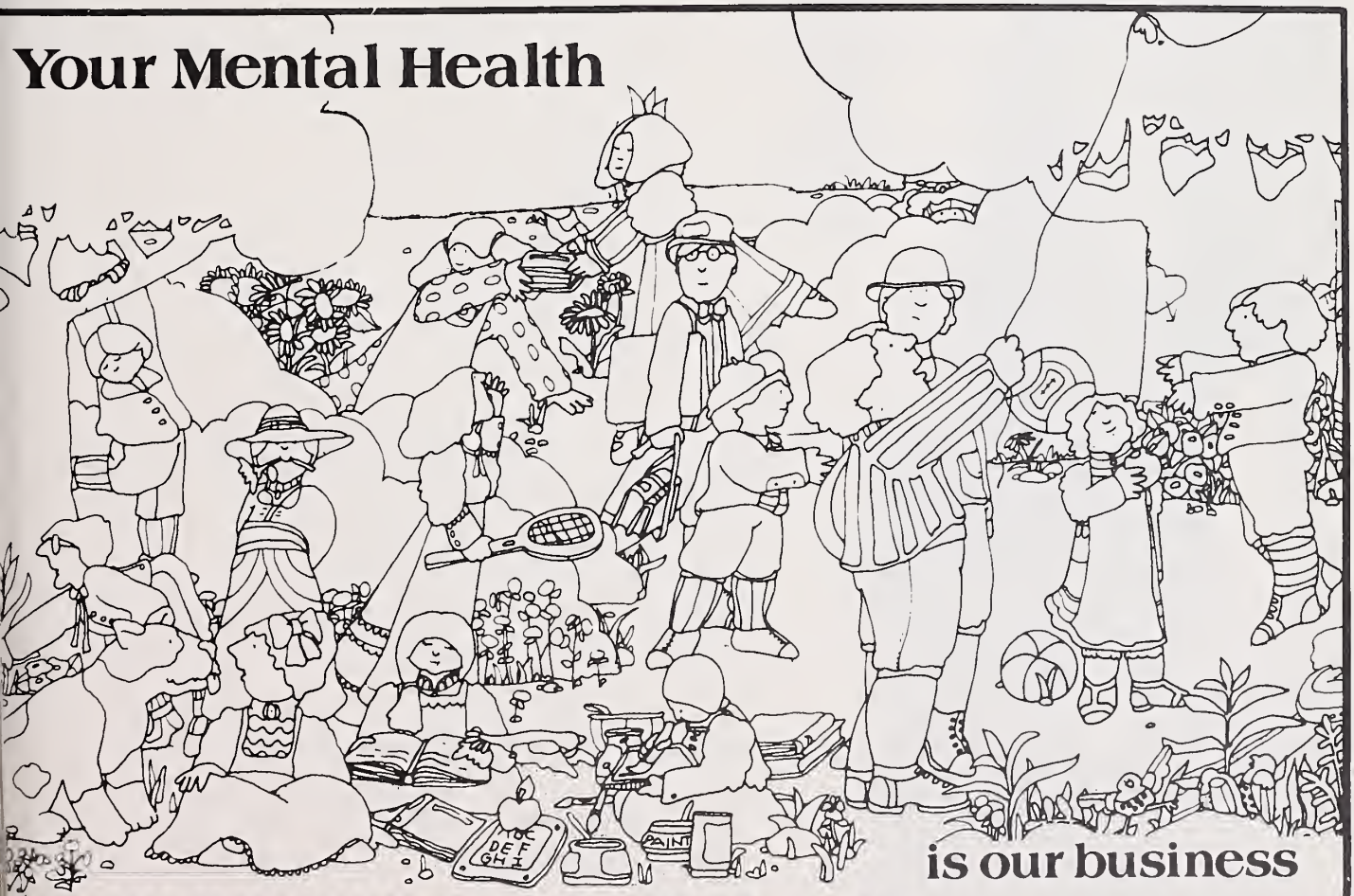
We want to express thanks to our customers this year for their friendship and patronage. We commit to them that our tradition of excellence will continue.

Guffey's
OF ATLANTA
Clothing for Men in Taste and Tradition

Peachtree Center
(Behind the Sculpture)
230 Peachtree Street, N.E.
404 522-0044

Guffey's

Tower Place
(At Piedmont Entrance)
3340 Peachtree Road, N.E.
404 231-0044
Ample Free Parking





Acute pain is no laughing matter.

The first prescription for the first days of acute pa

Empirin® c̄ Codeine

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). Ⓒ III

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin c̄ Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin c̄ Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin c̄ Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.) Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal trolled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug sh be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, gen anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) tantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal develop Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the pote benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capaci elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesion a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnos clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderl debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prost hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizzin sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory patients some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include eupho dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drow ness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspi Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated admin tion of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

Wellcome | Burroughs Wellcome C
Research Triangle Pa
North Carolina 27709

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

TEGA-VERT CAPSULES

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

Each capsule contains:

Pentylenetetrazol (Metrazol)	50 mg.
Niacin (Nicotinic Acid)	50 mg.
Dimenhydrinate (Dramamine)	25 mg.

ADMINISTRATION & DOSAGE: One or two capsules three or four times daily before or after meals.

INDICATIONS: TEGA-VERT is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: TEGA-VERT should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

ORTEGA PRODUCTS ARE DESIGNED WITH THE FAMILY PHYSICIAN IN MIND

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

Index to Advertising

Vol. 69 November 1980 No. 11

American Medical Association 918, 950
Anderson-Clayton Foods 886
Ballard, Walter, Optical Company 930
Boots Pharmaceutical 931-934
Brawner Psychiatric Institute 945
Burroughs Wellcome Company 937, 946
Classifieds 949
Cherokee Log Homes 952
Decatur Hearing Aid Service 929
Dickey-Mangham Company 929
Fulton Federal Savings and Loan Association 898
Global Imports 927
The Great Cherokee Trading Company 930
Guffey's of Atlanta 945
Hickman-Datsun 930
House of Persia 927
Insurance Corporation of America 903
Janssen Pharmaceuticals 928, 929
JMAG Classifieds 885, 945
Lenbrook Properties 942
Lilly, Eli, and Company 938
MAG Scientific Assembly 890
Marion Laboratories 900
Metro Ambulance 939
Newtron Sales 945
Nutrition Services Center 930
Ortega Pharmaceutical Company, Inc. 947
Peachford Hospital 922, 923
Peachtree and Parkwood Mental Health Center and Hospitals 889
PMMI/Med Data, Ltd. 899
Potter-Holden and Company 937
Psychiatric Institute of Atlanta 926
Ridgeview Institute 940
Roche Laboratories 884, 885, 911, 915-916
The Rocker Shop 899
U.S. Army 892
United Way 914
The Upjohn Company 912-914
Valley Psychiatric Hospital 947
Weight Watchers of Greater Atlanta 927
Willingway Hospital 902
Wyeth Laboratories 893, 894, 950, 951

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal*. Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$10.00 for the first 25 words; $.25 per word for each additional word. **Non-members**—$20.00 for the first 25 words; $.25 per word for each additional word. *Charges are payable in advance*. Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535. INWATS in Georgia (800) 282-0224.

PHYSICIANS WANTED

Non-profit organization needs a Family or General Practitioner and one (1) Nurse Practitioner for a primary care medical facility. Guaranteed salary while establishing practice, with Purchase Option. Available January, 1981. Please write Box 10-A, c/o the *Journal,* 938 Peachtree St., NE, Atlanta, GA 30309.

Emergency Room Physician Needed. 274-bed hospital. E.R. sees approximately 35,000 patients annually. Five-man rotation. Excellent benefit package. Send inquiry and CV to: Medical Affairs, Athens General Hospital, 797 Cobb St., Athens, GA 30606.

Needed immediately, family practitioner or GP for Fairburn area. Medical office space available. 1,500 sq. ft. Free parking. Contact Leon Hudson, PO Box 187, Fairburn 30213. After 7:00 p.m., (404) 964-4493.

Surgery Director. Opening for Director of Residency Training Program in Surgery with Pensacola Education Program, Pensacola, Florida, for Board-certified physician. Total program of 52 residents in six different residencies (7 residents in 5-year Surgical Program) associated with 4 different hospitals in community-based educational program. Salary competitive, with excellent fringe benefits of paid vacation, liability insurance, health and disability insurance, paid educational and professional trips. Program affiliation with several large medical schools. Gulf Coast living at its best and health care in immediate area of over ¼ million. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education, 904/477-4956, or send CV to Director of Medical Education, Pensacola Educational Program, 5149 N. Ninth Ave., Ste. 307, Pensacola, FL 32504.

SITUATIONS WANTED

Locum tenens work wanted. Family and General practice, open availability. T. C. Kolf, M.D., (801) 566-1666.

Board certified, young internist is looking for association in a group or clinic, or purchase of an active practice. Atlanta vicinity preferred. Write Box 11-A.

University of Tennessee graduate. Residency trained in internal medicine. Board eligible. Georgia licensed. Desires locum tenens, full or part time work in emergency room, general medicine or research in Georgia. Available immediately. Please respond to W. Bow, M.D., 1386 Favell Dr., Memphis, TN 38116. PH: (901) 942-5749 until 4 p.m.; Georgia phone (404) 485-8689.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call (404) 634-1234.

Active private practice, with private 20-bed hospital for sale. Sale is due to physician's declining health. Reply by phone only: (912) 862-3265 or 862-3285.

Well-established general practice with fully equipped, large office available immediately to American-trained physician. Adjacent to 65-bed modern general hospital. Terms available on equipment. Please respond to Box 11-B, c/o the *Journal,* 938 Peachtree St., NE, Atlanta, GA 30309.

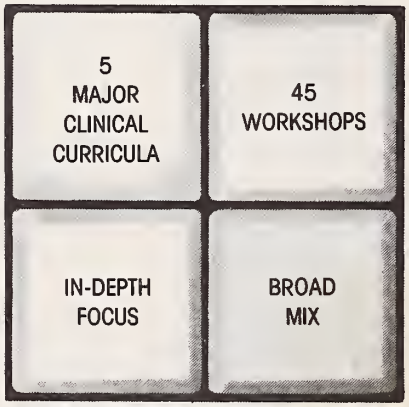
HANDICAPPED PHYSICIANS

I am a multiply-handicapped doctor interested in contacting other handicapped physicians in order to obtain some approximation of the size and characteristics of this population in the United States and Canada. There is currently no organization to provide statistical data on the career patterns of such individuals or to what extent various handicaps affect the physician's ability to remain in active practice. Should any physician become handicapped, such information would be of utmost value in determining the feasibility of remaining in any chosen field and would also provide some indication of the career opportunities available to this unique population.

All physicians, active or inactive, with any type of physical handicap are asked to contact F. Zondlo, M.D., St. Paul-Ramsey Medical Education and Research Foundation, 640 Jackson St., St. Paul, MN 55101.

Design your own program of CME at AMA Winter Scientific Meeting

Choose from:



Atlanta, GA; Jan. 24-26, 1980

To minimize interruption to your practice, the meeting will be three days, Saturday, through Monday.

But even more important is the new program design which allows you to tailor a program to your specific requirements. You can choose from five major clinical curricula: GI Disease, Cardiac Disease, Pulmonary Disease, Drug Therapy, Infectious Diseases. 45 different workshops (three workshops each day in each of the five clinical areas) are offered.

AMA Auxiliary Plans

Be sure to bring your spouse along with you because the AMA Auxiliary has planned a number of interesting and exciting tours and educational sessions.

Dept. of Meeting Services
American Medical Association
535 N. Dearborn St.
Chicago, IL 60610

Please send me complete information on the AMA Winter Scientific Meeting in Atlanta, Jan. 24-26, 1980.

() Please send information on the AMA Auxiliary Activities.

Name_____

Address_____

City_____

State/Zip _____

CYCLAPEN®-W (cyclacillin)

Indicotions
Cyclocillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treotment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemalytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbotion of chronic bronchitis caused by *H. influenzae**

*Though clinicol improvement hos been shown, bacterialogic cures cannot be expected in all patients with chronic respirotory diseose due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentory) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinose producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in ony *E. coli* ond *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy ond susceptibility of bacterio. Theropy may be instituted priar to results of sensitivity testing.

Controindicotions Controindicated in individuals with history af an allergic reaction ta penicillins.

Wornings Cyclacillin should only be prescribed for the indicotions listed herein.

Cyclocillin hos less in *vitro* octivity thon other drugs of the ampicillin closs. However, clinicol triols demonstroted it is efficacious for recommended indicotions.

Serious and occosionol fotol hypersensitivity (onophyloctoid) reoctions hove been reported in potients on penicillin. Although onophyloxis is more frequent following porenterol use, it hos occurred in patients on orol penicillins. These reoctions ore more opt to occur in individuals with history of sensitivity to multiple ollergens. There ore reports of potients with history of penicillin hypersensitivity reoctions who experienced severe hypersensitivity reoctions when treoted with a cephalosporin. Before penicillin theropy, corefully inquire obout previous hypersensitivity reoctions to penicillins, cepholosporins ond other ollergens. If ollergic reoction occurs, discontinue drug ond initiote oppropriote theropy. Serious onophyloctoid reoctions require immediote emergency treotment with epinephrine. Oxygen, I.V. steroids, oirwoy monogement, including intubotion, should olso be odministered os indicated.

Precoutions Prolanged use of ontibiotics moy pramate overgrowth of nonsusceptible orgonisms. If superinfection occurs, toke appropriate meosures.

PREGNANCY: Pregnancy Cotegary B. Reproduction studies performed in mice and rats at doses up to 10 times the humon dose reveoled no evidence of impoired fertility ar harm to the fetus due ta cyclocillin. There are, however, no odequote and well-controlled studies in pregnont women. Becouse animal reproduction studies are not olways predictive af human response, use this drug during pregnoncy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs ore, exercise coution when cyclocillin is given to o nursing woman.

Adverse Reactions Oral cyclocillin is generally well tolerated. As with other penicillins, untoword sensitivity reactions ore likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hoy fever, ar urticorio. Adverse reactions reported with cyclacillin: diarrheo (in opproximately 1 out of 20 potients treated), nauseo ond vomiting (in approximotely 1 in 50), and skin rosh (in opproximately 1 in 60). Isoloted instances of heodoche, dizziness, abdominol poin, vaginitis, and urticorio hove been reported. (See WARNINGS) Other less frequent odverse reactions which moy accur and are reported with other penicillins ore onemia, thrombocytopenio, thrambacytopenic purpura, leukopenio, neutrapenia and eosinophilia. These reactions ore usually reversible on discontinuation af therapy.

As with other semisynthetic penicillins, SGOT elevotians have been reported.

As with antibiotic theropy generally, continue treatment ot leost 48 ta 72 hours ofter patient becomes osymptomatic or until bacterial eradicotion is evidenced. In Graup A beta-hemolytic streptococcal infections, at leost 10 days' treotment is recommended to guard against risk of rheumatic fever or glamerulonephritis. In chronic urinory tract infection, frequent bacteriologic and clinical opproisol is necessary during therapy and possibly far severol manths after. Persistent infection moy require treatment for severol weeks.

Cyclacillin is not indicated in children under 2 months af age.

Patients with Renal Failure Cyclocillin may be safely odministered to potients with reduced renol function. Due ta prolonged serum half-life, patients with variaus degrees of renal impairment may require change in dasage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equolly spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratary Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Maderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/doy q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/doy

*Dosage should not result in a dose higher than that for adults.
†depending on severity

Wyeth Laboratories
Philadelphia, Pa. 19101

JOURNAL
of the medical association of
georgia
ISSN 0025-7028 DECEMBER/1980

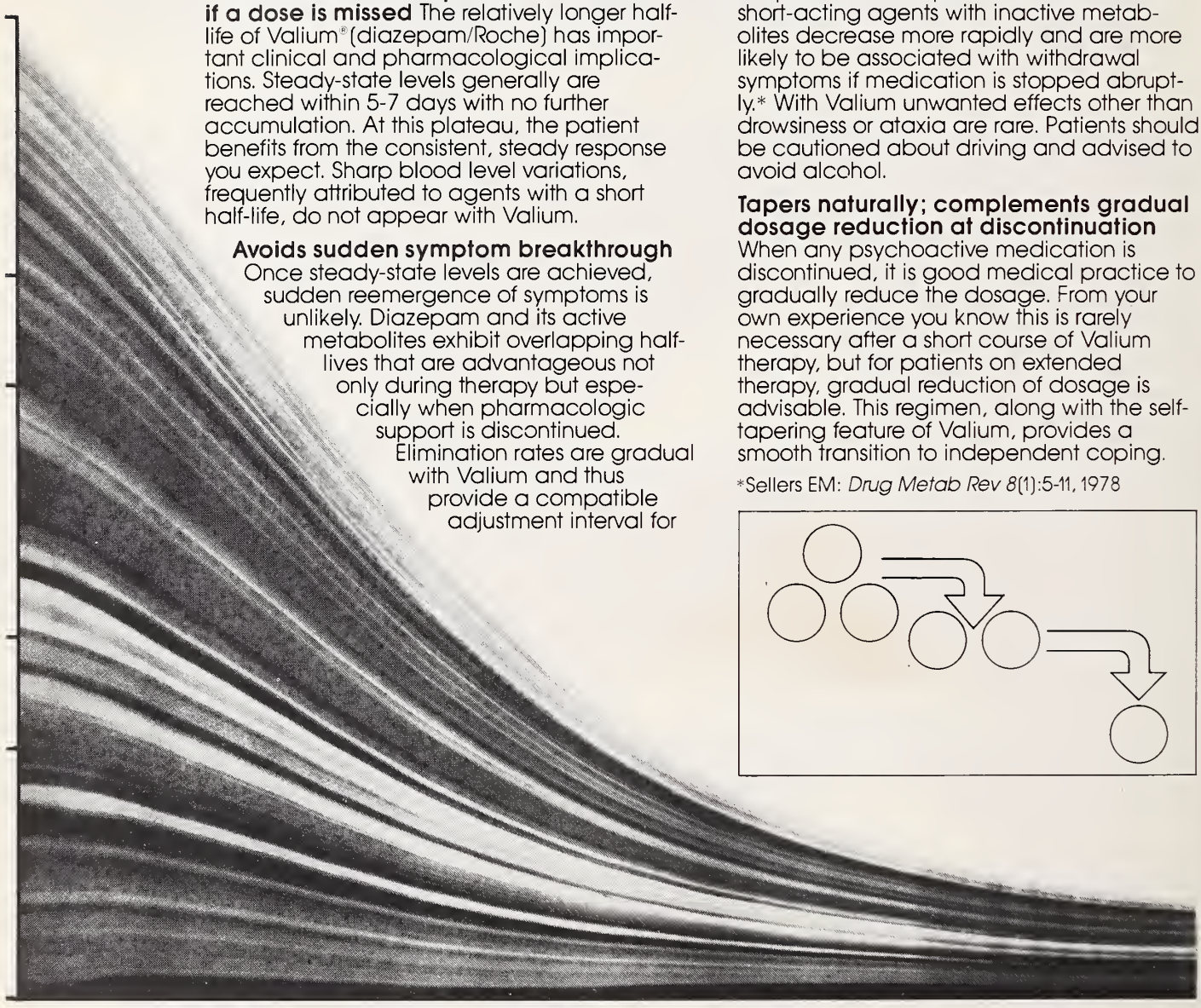
LIBRARY
U.C. SAN FRANCISCO
FEB 3 1981

AMA WINTER SCIENTIFIC MEETING

January 24-26, 1981
Atlanta, Georgia

half-life

Just one built-in advantage



Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978

in the management of symptoms of anxiety

Valium®(IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

Before prescribing, please see summary of product information on next page.

ROCHE®

Valium®IV
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TALK IS CHEAP

in the *Journal*'s Classifieds

Do you want to buy a boat? Or sell some office equipment? Or find a new associate? Or rent a vacation home? The ***Journal*'s Classifieds** is the inexpensive way to get your message with thousands of others who share your professional and recreational interests.

DECATUR HEARING AID SERVICE

Many makes and models to choose from.
Expertly fitted for your individual hearing loss.
Batteries, Accessories, and Repairs.

Suite 211,
Decatur Clinic Bldg.
235 E. Ponce de Leon Ave.
Decatur, Ga. 30030
(404) 373-9521



R.H. BAKER
21 Years' Service

Our performance record is substantially better than Dow Jones'

Mark Fine's investment recommendation record of the past six years* has produced an average rise of 172% compared to the six year average rise by the Dow Jones Industrials of only 10%. Getting in top financial form and staying there takes time, effort and guidance. We'll be your guidance to a secure financial future with successful investing and money management. Call us . . . it could change your profit picture for good.

*Mark Fine first formed his own company in 1974.

September 15, 1980

HISTORY OF RECOMMENDATIONS OF MARK FINE, SINCE FORMING HIS OWN BUSINESS IN 1974

STOCK	PRICE—DATE OF RECOMMENDATION		PRICE 9/15/80	% INCREASE (LOSS)
H&R BLOCK	11	5/6/74	31	182%
COMBINED COMMUNICATIONS 4)	3	12/23/74	43	1330%
COX BROADCASTING 7,5)	5	12/23/74	42	740%
ROLLINS, INC.	17	3/27/74	33	94%
JOHN HARLAND 8)	14	4/2/74	40	185%
BURNUP AND SIMS	19	4/15/74	15	(21%)
HOSPITAL CORPORATION OF AMERICA 1)	14	4/28/76	50	256%
AMERICAN MEDICORP 3)	7	4/28/76	23	228%
AMIC CORPORATION 6)	11	12/4/76	26	136%
UNITED GUARANTY 1)	10	12/4/76	29	190%
RMIC CORPORATION 2)	6	12/4/76	25	317%
MGIC	15	2/27/78	31	106%
CAPITAL CITIES 5)	28	2/27/78	66	135%
LEVITZ	23	5/12/78	29	26%
XTRA 5)	16	10/30/78	20	25%
EASTERN AIR LINES	9	10/30/78	9	0%
HUGHES TOOL 8)	28	2/7/79	72	157%
SYNTEX	38	8/2/79	52	37%
CHURCH'S FRIED CHICKEN	24	2/12/80	26	8%
GENERAL INSTRUMENTS	40	3/27/80	73	82%
McDONALD'S	38	3/27/80	47	24%
SMITH-KLINE	47	3/27/80	58	23%
SCIENTIFIC ATLANTA 5)	17	3/27/80	41	141%
SEA CONTAINERS	20	6/2/80	27	35%
TELEPROMPTER	18	6/2/80	25	39%
CITICORP	23	7/15/80	23	0%

6 YEAR AVERAGE RISE OF MARK FINE'S RECOMMENDATIONS **172%**

***6 YEAR AVERAGE RISE OF DOW JONES INDUSTRIALS** **10%**

*DJI 3/28/74	850
DJI 9/15/80	937

1) Adjusted for 5—4 Stock Split; 4—3 Split-78
2) Adjusted for 30% Stock Dividend '77 25% S/DIV-'78; 10% S/DIV-'79
3) Close out buy recommendation 2/6/78
4) Adjusted for 3—2 Stock Split-Merged with Gannett-2 Q-79
5) Adjusted for 2—1 Stock Split
6) Adjusted for 3—2 Stock Split; Close out by recommendation 2/7/79
7) Close out buy recommendation 6/5/79
8) Adjusted for 3—2 Stock Split

SM F&C

S.M. Fine and Company

Members Midwest Stock Exchange Member SIPC

Mark Fine — President 256-3170
140 Prado East/5600 Roswell Road, N.E./P.O. Box 76760/Atlanta, Georgia 30328

JOURNAL
of the medical association of
georgia

contents

VOLUME 69, NUMBER 12

EDITOR
Edgar Woody Jr., M.D.

MANAGING EDITOR
Susan J. Dillon

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Jack A. Raines, M.D., Columbus
Carson B. Burgstiner, M.D., Savannah
Patrick C. Shea Jr., M.D., Atlanta
A. Calhoun Witham, M.D., Augusta

PUBLICATIONS COMMITTEE/
EXECUTIVE COMMITTEE OF
THE BOARD OF DIRECTORS
H. Hilt Hammett Jr., M.D., LaGrange
President
L. Newton Turk III, M.D., Atlanta
President-Elect
Earnest C. Atkins, M.D., Atlanta
Immediate Past President
S. William Clark Jr., M.D., Waycross
First Vice President
Michel A. Glucksman, M.D., Brunswick or
William C. Collins, M.D., Atlanta
Second Vice President
Jack A. Raines, M.D., Columbus
Chairman of the Board of Directors
William D. Logan Jr., M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
Jack F. Menendez, M.D., Macon
Speaker of the House
James A. Kaufmann, M.D., Atlanta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Rusty Kidd, Associate Executive Director
Joyce Butler, R.N., Assistant Executive Director
J. Tom Sawyer, Assistant Executive Director
Kenneth M. Williams, Director of Public and Professional Relations
Stephen Davis, Director of Education
Bert Franco, M.A., Assistant Director of Medical Practice
Gary W. Price, Assistant Director of Legislative Activities
Miriam McLendon, Administrative Assistant to the Executive Director

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Board of Directors of the Association. Printed by The Ovid Bell Press, Inc., Fulton, Missouri.

Copyright, 1980, Medical Association of Georgia. Advertisements for products or services that appear in the *Journal* are not necessarily endorsed by the Association.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price for nonmembers is $10.00 in the United States, Canada and Mexico, and $12.00 in other countries. Single copies are $2.

The *Journal of the Medical Association of Georgia* is published monthly at 938 Peachtree Street, N. E., Atlanta, Georgia 30309. Second-class postage paid at Atlanta, Georgia, and at additional mailing offices. POSTMASTER: Send address changes to Medical Association of Georgia, 938 Peachtree Street, N. E., Atlanta, Georgia 30309.

SCIENTIFIC ARTICLES

971 *Campylobacter fetus* subspecies *jejuni* in Georgia
Timothy J. Barrett
Paul A. Blake, M.D.
Davie Sweet
977 Jehovah's Witness, How Can We Help Them?
M. M. Fatteh, M.D.

SPECIAL ARTICLES

965 The Library Consortium — Service for Community Hospitals in Georgia
J. A. Rankin, M.L.N.
M. L. Dykes, M.S.
C. B. Reid, M.S.L.S.

EDITORIALS

982 Correcting a Bad Impresssion
Rev. Daniel P. Matthews
983 AMA — Atlanta — MAG Winter Scientific Meeting
LaMar S. McGinnis, M.D.
984 Facility Fees — To Be or Not To Be
Walter S. Dunbar, M.D.

FEATURES

987 Legal Page/ Dealing With Formal and Informal Requests From Attorneys for Production of Patient Records in Connection With Civil Litigation
Robert N. Berg
991 Heart Page/ Recommendations for Phonocardiography
Barry D. Silverman
995 Cancer Page/How Often Should a Pap Test Be Done?
John L. Powell, M.D.

ASSOCIATION PAGES

1008 President's Letter/A Champion — Attitude and Desire
H. Hilt Hammett, Jr., M.D.
1009 New Members
1010 Personals
1010 Societies
1010 Deaths
1011 Two New Members Join MAG Staff
1011 Physicians' Recognition Award Recipients
1012 Auxiliary to MAG Sponsors Two Health Workshops
1012 Physician Involvement Program (PIP)
1012 Physicians Invited to Attend a Medical Historical Meeting

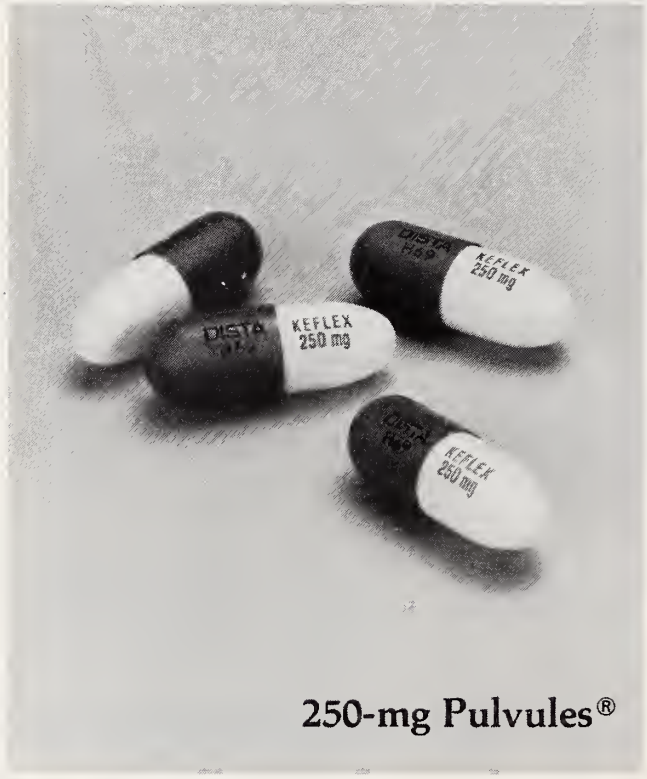
INCIDENTAL INTELLIGENCE

960 Medical Meeting Calendar

COVER

The AMA Winter Scientific Meeting is highlighted on the cover this month. This meeting will certainly be a highlight this winter in the AMA's excellent programs for continuing medical education. Georgia physicians are fortunate to have this CME opportunity at our own "Doorstep."

easy to take



250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops



100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

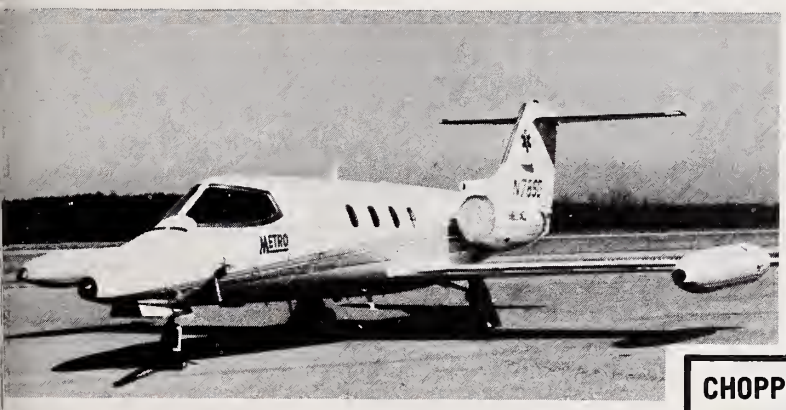
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

For your patients' critical transportation . . .

Rely on METRO

AMBULANCE SERVICE, INC.
MARIETTA, GEORGIA

AIR ONE



- **LEAR JET** — 550 MPH — Pressurized Cabin — Radar — Co-pilots
- **HELICOPTER** — 150 MPH — Flying Intensive Care Unit

SPECIALIZED TRANSPORT TEAMS

- NEONATAL
- AORTIC BALLOON PUMP
- STRYKER FRAME
- BURN

CHOPPER ONE



MICU 101



PROFESSIONAL STAFF

- REGISTERED NURSES
- PARAMEDIC TECHNICIANS
- RESPIRATORY THERAPISTS
- CARDIAC TECHNICIANS
- ADVANCED EMTs
- PHYSICIANS ON CALL 24 HOURS A DAY . . . EVERY DAY

- **MOBILE INTENSIVE CARE UNITS** Equipped as Mobile Hospital

METRO

AMBULANCE SERVICE, INC.
P.O. BOX 195
MARIETTA, GEORGIA 30061

Any Patient — Any Equipment Anytime

—— **CALL TOLL FREE** ——

GEORGIA 1-800-282-7984

NATIONWIDE 1-800-241-7763

MEDICAL MEETING CALENDAR

DECEMBER

12—*Atlanta;* **SIXTH ANNUAL INFECTIOUS DISEASES SEMINAR—1980;** Category 1 credit; Contact: Dept. of Graduate and CME, GA. Baptist Med. Ctr., 300 Boulevard, NE, Atlanta, 30312. PH: 404/659-4211, ext. 2346.

12-13—*Jackson, MS;* **THIRD ANNUAL COURSE ON STRABISMUS;** Contact: Dr. Raul E. Valenzuela, Univ. of Mississippi Med. Ctr., 2500 N. State St., Jackson, MS 39216.

22:31—*Aspen, CO;* **MEDICAL LEGAL SEMINAR;** Contact: B. J. Cahn, MD, 3576 Chamblee-Tucker Rd., Atlanta 30341. PH: 404/934-3326.

JANUARY 1981

14-18—*Miami, FL;* **NEUROLOGICAL UPDATE—1981;** Contact: Div. of CME, Univ. of Miami Sch. of Med., Box 016960, Miami, FL 33101.

19-24—*Augusta;* **FAMILY PRACTICE SYMPOSIUM;** Category 1 credit; Contact: Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

22-24—*Charleston, SC;* **ALLIANCE FOR CONTINUING MEDICAL EDUCATION;** Contact: Lewis Miller, ACME, 322 Westport Ave., Norwalk, CT 06851. PH: 203/846-3441.

24—*Atlanta;* **22ND AMA NATIONAL CONFERENCE ON THE MEDICAL ASPECTS OF SPORTS;** Category 1 credit; Contact: AMA Dept. of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

24-26—*Atlanta;* **AMA WINTER SCIENTIFIC MEETING;** Category 1 credit; Contact: Council on Cont. Physician Education, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

24-31—*Snowmass, CO;* **FIFTH ANNUAL CONFERENCE ON PAIN: FACIAL AND NECK PAIN;** Category 1 credit; Contact: Ronald G. Havican, Ctr. for Rehab. Med., Emory Univ. Sch. of Med., 1441 Clifton Rd., NE, Atlanta 30322. PH: 404/329-5507.

26-31—*Puerto Rico;* **PEDIATRICS IN REVIEW—1981;** Contact: Judson Hawk Jr., MD, Scottish Rite Hospital for Crippled Children, 1001 Johnson Ferry Rd., Atlanta 30342.

26-February 6—*Atlanta;* **LAB DIAGNOSIS OF VIRAL DISEASES;** Contact: CDC, Bureau of Labs, Public Health Service, 1600 Clifton Rd., Atlanta 30333.

FEBRUARY 1981

2-5—*Miami, FL;* **FLORIDA MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY;** Contact: Fla. Midwinter Seminar, Univ. of Miami Sch. of Med., 405 NE 144 St., Miami, FL 33161.

5-7—*Lexington, KY;* **FIBEROPTIC BRONCHOSCOPY;** Category 1 credit; Contact: Frank R. Lemon, MD, Cont. Ed., College of Medicine, Univ. of Kentucky, Lexington, KY 40536. PH: 606/233-5161.

13-14—*Atlanta;* **TREATMENT OF PARANOID CONDITIONS;** Contact: Ga. Psychiatric Assn., 130 Sixth St., NW, Atlanta 30313.

15-20—*Lexington, KY;* **TWELFTH FAMILY MEDICINE REVIEW — SESSION I;** Category 1 credit; Contact: Frank R. Lemon, MD, Cont. Ed., College of Medicine, Univ. of KY, Lexington, KY 40536. PH: 606/233-5161.

16-20—*Savannah;* **CURRENT METHODS IN BLOOD BANKING AND IMMUNO-HEMATOLOGY;** Contact: American Society of Clinical Pathologists, 2100 W. Harrison, Chicago, IL 60612.

18-24—*Cancun, Mexico;* **ADVANCES IN CLINICAL MEDICINE;** Category 1 credit; Contact: Michael B. Kessler, MD, Director, Physicians Medical Seminars, 970 Clemenstone Dr., Atlanta 30342. PH: 404/971-8797.

22-25—*New Orleans, LA;* **SOUTHEASTERN SURGICAL CONGRESS 49TH ANNUAL ASSEMBLY;** Category 1 credit; Contact: Southeastern Surgical Congress, 315 Boulevard, Ste. 500, Atlanta 30312. PH: 404/681-3636.

MARCH 1981

2-6—*Chicago, IL;* **70TH ANNUAL MEETING OF THE U.S.-CANADIAN DIV. OF INTERNAT'L ACADEMY OF PATHOLOGY;** Contact: Nathan Kaufman, Sec.-Treas., U.S.-Canadian Div. of the Internat'l Academy of Pathology, 1003 Chafee Ave., Augusta 30904. PH: 404/724-2973.

3-6—*Durango, CO;* **EMERGENCY MEDICINE-TRAUMA;** Category 1 credit; Contact: Div. of Cont. Ed., MCG, Augusta 30912. PH: 404/828-3967.

4-6—*Houston, TX;* **MOLECULAR INTERRELATIONS OF NUTRITION AND CANCER;** Contact: Stepehen C. Stuyck, Director, Public Information and Education, M.D. Anderson Hospital and Tumor Institute, Houston, TX 77030. PH: 713/792-3030.

8-11—*Denver, CO;* **FOURTH ANNUAL CONFERENCE ON RURAL PRIMARY CARE;** Contact: National Conference, NRPCA, Box 1211, Waterville, ME 04901. PH: 207/873-1127.

8-15—*Maui, HI;* **POSTGRADUATE COURSE IN SPORTS MEDICINE;** Category 1 credit; Contact: Marianne Porter, Ctr. for Sports Medicine, 303 E. Chicago Ave., Chicago, IL 60611. PH: 312/649-7959.

15-16—*Orlando, FL;* **INTERNATIONAL GLAUCOMA CONGRESS;** Contact: American Society of Contemporary Ophthalmology, 6 N. Michigan Ave., Room 1110, Chicago, IL 60602.

18-19—*New York, NY;* **29TH NATIONAL HEALTH FORUM;** Contact: National Health Council, 70 W. 40th St., Fourth Floor, New York, NY 10018.

21-22—*Tampa, FL;* **CONTROVERSIES IN PULMONARY MEDICINE;** Contact: Univ. of So. Fla. College of Med. Dept. of Internal Med., 12901 N. 30th St., Tampa, FL 33612.

22-25—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Contact: Med. Assn. of Atlanta, 875 W. Peachtree St., NE, Atlanta 30309.

23-25—*Savannah;* **SELECTED TOPICS IN PEDIATRIC OPHTHALMOLOGY;** Contact: Div. of Cont. Ed., MCG, Augusta, GA 30912. PH: 404/828-3967.

23-25—*Jekyll Island;* **PEDIATRIC OPHTHALMOLOGY;** Contact: MCG, Sch. of Med., Augusta 30912.

For additional information on these and other meetings, contact the Education Division, MAG Headquarters, 938 Peachtree St., N.E., Atlanta, GA 30309. Information on upcoming medical meetings should be sent well in advance to the foregoing address.

70 GEORGIA PROVIDERS HAVE SOLVED THEIR MEDICAID PROCESSING PROBLEMS.

MEDICARE, YOU'RE NEXT!

Our unique computerized system has reduced the Medicaid claim turn-around to 12 days.

Call or write for more information on paperless claims processing.

- IMPROVED CASH FLOW
- REDUCTION IN PAPERWORK
- ELIMINATION OF LOST CLAIMS
- PROVIDER CONTROL
- PURITY OF DATA

Emerson Center
2814 New Spring Road, Suite 121
Atlanta, Georgia 30339
(404) 436-2121

MD
Med Data Ltd.

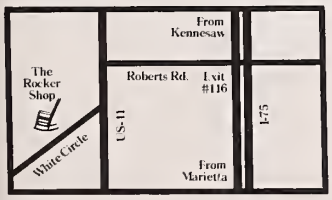
ROCKING THE NATION FOR OVER 100 YEARS...THE ONE AND ONLY BRUMBY ROCKER, ONLY AT THE ROCKER SHOP.

Few things have withstood the test of time as the Brumby Rocker. From it's early southern heritage, to today's White House, the Brumby has established a reputation as the world's finest handcrafted rocker. The moment production begins, to the moment we sell it to you, the Brumby is treated with the finest skill and care. The same skill and care used over 100 years ago when Brumbys were first made in 1875.

A Brumby Rocker is an investment in a future family heirloom. In fine homes throughout the country it has become a part of the family, rocking generations of children and a source of relaxation for all.

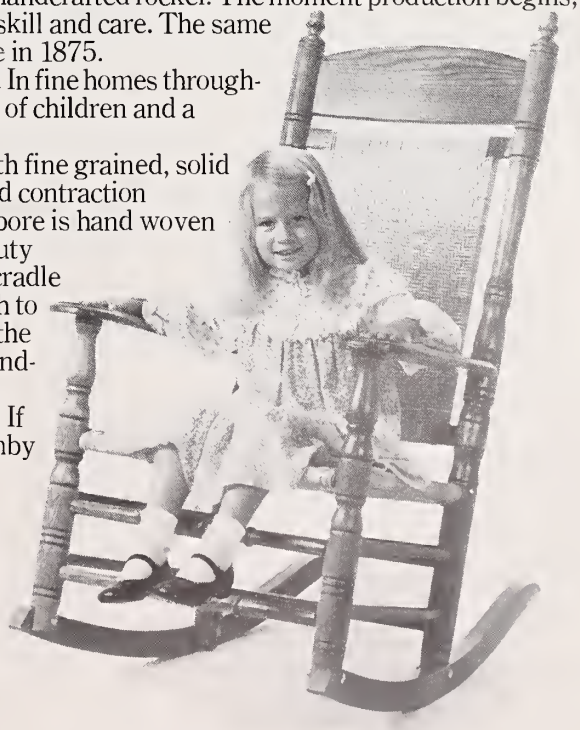
What gives the Brumby this enduring popularity? It begins with fine grained, solid oak which is half air dried and half kiln dried for natural expansion and contraction which helps prevent warping or bending. "Blue Tie" cane from Singapore is hand woven on both sides of the seat and back for comfortable cushioning and beauty from every angle. The steam bent back posts are curved to naturally cradle your back. The extra wide runners are designed with a slight rear arch to give an even rock and help prevent tipping. The man-size arms, with the original Brumby seal, let you rest your elbows comfortably. All are hand-sanded to a warm finish that accentuates the fine grained wood.

Good things are hard to find, but always well worth the search. If the Rocker Shop is a little out of your way, we'll gladly ship your Brumby Rocker anywhere. Major credit cards accepted.



The Rocker Shop of Marietta, Georgia

1421 White Circle, N.W. • P.O. Box 12
Marietta, Georgia 30061 • (404) 427-2618





"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

PAVABID® AND PAVABID® HP

(papaverine hydrochloride)
150-mg Capsules 300-mg Capsulets

Patient benefit products from

PHARMACEUTICAL DIVISION
MARION LABORATORIES, INC.
KANSAS CITY MO 64137

6'90

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

© SK&F Co., 1980

SK&F CO.
a SmithKline company
Carolina, P.R. 00630



works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.



- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.
- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

JOURNAL
of the medical association of
georgia

The Library Consortium — Service for Community Hospitals in Georgia

J. A. RANKIN, M.LN., *Macon,* M. L. DYKES, M.S., *Griffin,* and C.B. REID, M.S.L.S., *Columbus**

History and Physical Examinations

NAME: Community Hospital, Anywhere, Georgia.

CHIEF COMPLAINT: Lack of current information flow into hospital staff, no new textbooks or journals, no systematic method to find information.

REVIEW OF SYSTEMS: No money in budget for library needs, no personnel trained and available to help, no area assigned as medical library space.

ADMITTING DIAGNOSIS: Chronic information malnutrition of the hospital staff.

PLAN: Patient needs referral to a medical information specialist ASAP.

EXAMINATION of Georgia's hospitals reveals that about 70% are affected by symptoms similar to those described above. There are no known sure-fire antidotes for rapid cure of "information malnutrition," but a new treatment — the medical library consortium — offers hope for substantial improvement.

Medical library consortia provide a method for the development of inexpensive, efficient library services in hospitals. These voluntary alliances bring with them access to the collective information resources of member institutions. They are networks which can address themselves specifically to the changing needs of the community hospital in the 1980s.

* Miss Rankin is Director, Medical Library, Mercer University School of Medicine, Macon, GA 31207; Miss Dykes is with the Griffin-Spalding County Hospital; and Miss Reid is with West Central Georgia Regional Hospital. Direct reprint requests to Miss Rankin at the above address.

Georgia's Community Hospitals

The small community hospital — it is a familiar, cherished institution which is in danger of extinction.

Recent advances in medical care have created expectations among professionals and lay persons that severely strain the economics of the small community hospital. The public sees escalating health care costs; the physician struggles to stay up-to-date and implement the most effective techniques and practices; the hospital manages only by a financial balancing act, seeking excellence of care and yet dealing simultaneously with inflation and cost containment programs.

Caught in the middle of this cost-conscious squeeze is the hospital's medical library. Library services, where they do exist, are usually inadequate for the majority of staff needs. Often the community hospital "library" occupies a corner of the staff conference room or the medical records department. Its function is limited to some donated and outdated medical school texts, perhaps a few stray *JAMA*s, and an occasional nursing journal. It has no trained staff, no effective budget, and inadequate space. The result is that the entire staff of the average community hospital suffers from "information malnutrition."

Why Strive to Improve Hospital Libraries

With the advent of a new decade, many Georgia hospitals are looking for ways to improve their libraries and to reap the benefits of timely, appropriate information. Effective information systems are needed to maintain quality care and comply with regulatory standards.

Library services in our hospitals are being scrutinized because of changes in the health care field in recent years. According to *Health Care Week*, "Hospitals across the country report that new rules in accreditation, education, labor practice, copyright law, and federal financing are pressuring them to set up in-house information services for their doctors and nurses. Small and isolated facilities are most affected by these changes."[1]

Health Care Week also names several recent events in the area of biomedical communications that have precipitated the creation of local information centers. At the national level, funding which supported free photocopies for physicians is being phased out, forcing local physicians and hospitals to absorb the cost of interlibrary loans themselves. Second, the 1978 Copyright Law greatly limits the number of photocopies that can be obtained. Third, continuing education is mandatory in many health fields, and recent legislation in many states calls for regular recertification and relicensure.

The Joint Commission on Accreditation of Hospitals (JCAH) has upgraded its standards for medical library services. JCAH now recommends that all accredited hospitals "provide library services to meet the informational, educational and, when appropriate, the research-related needs of the medical and hospital staffs:

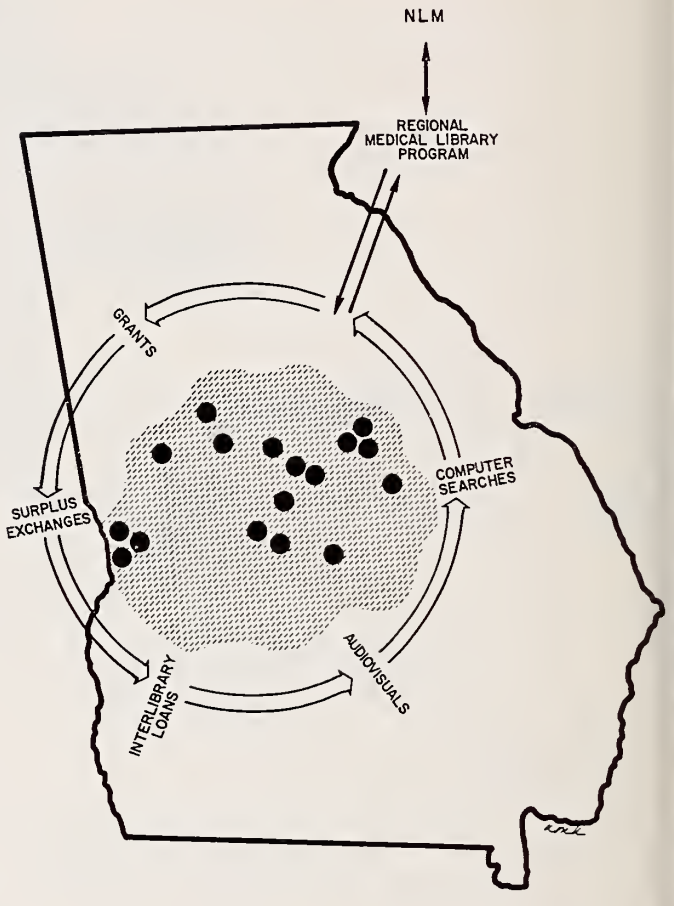
> *The professional library shall have an up-to-date, authoritative collection of print and nonprint materials, including recent editions of textbooks and current periodicals pertinent to the clinical, educational, and research services offered. The Index Medicus or Abridged Index Medicus and its cumulations, and, as appropriate, hospital, nursing, and dental indexes, should be provided. Document reproduction and delivery service, audiovisual services, and bibliographic sources should be included in the professional library services available.*[2]

Close-Up of Health Sciences Libraries of Central Georgia (HSLCG)

As independent institutions, many small rural hospitals are finding themselves hard pressed to comply with the new regulations to upgrade their libraries. Across the country, consortia are serving as an innovative response to demands for improved information services.

The HSLCG is an example of one consortium that has stimulated significant improvement in hospital information services. HSLCG was organized in October, 1975, in response to a generally recognized need to upgrade information services to health professionals in central Georgia. It is now successfully meeting many of the needs of smaller hospitals and

HEALTH SCIENCE LIBRARIES OF CENTRAL GEORGIA



accomplishing this more effectively and economically than could any single, isolated library unit.

Consortia may be structured either formally or informally. They may include any number or combination of information-providing operations. Most consortia share library materials such as books, journals, audiovisuals, as well as access to computerized information retrieval systems. Some hospitals join together to contribute to the salary of a certified medical librarian who travels to the various institutions, coordinating and administering information services. All consortia serve as a forum for educating hospital employees who are working with the library about more effective library practices.

HSLCG defined its objectives and developed its program after looking at the situation *vis-à-vis* health resources existing in central Georgia in the mid 1970s. Although the region includes two small metropolitan areas, Macon and Columbus, the central Georgia area is predominately rural and poor. There are 34 hospitals; 65% have less than 100 beds. Much of the patient care is delivered in small facilities. Overall, in rural central and south Georgia, the physician-patient ratio is about 1:2,300.

Health professionals under such circumstances have an enormous task. They require a system of information delivery that is responsive to their

needs, that calls for the least possible expenditure of time on their part, and that promptly delivers needed information.

To respond to these needs, HSLCG organized to share resources, services and personnel expertise and to develop a regional library system not confined by institutional barriers. First, a manageable target area was identified and health institutions inside this geographic region were surveyed for potential interest. Because of the sparsity of available resources, a membership was sought that would allow the group to tap most of the relevant information resources available in the area.

In the 5 years since its inception, the HSLCG consortium has made encouraging progress. Initially organized with only three members, HSLCG now includes 17 institutions and is continuing to grow and expand its base of resources. Consortium-related library services are presently being extended to health professionals in 11 counties. HSLCG members include academic and health care delivery institutions, general and specialty hospitals, and schools with health-related education programs. The 12 hospital members include city-county, county, state, and federal operations.

Much of the strength of the consortium lies in the diversity of its membership. Member institutions are involved at many levels of the health care education and delivery system. This variety has the advantage of providing the consortium membership with a wealth of information resources ranging from the pre-clinical sciences to the medical specialties, and to many of the allied fields, such as nursing, psychology, and social work. Even small facilities find they have something to offer even though their book and journal collections are quite limited.

Among the most visible benefits of HSLCG membership are interlibrary loans and sharing of library resources. Also, assistance in locating source material for needed information is offered by members with larger reference collections. Other advantageous programs include swapping surplus items, cooperative acquisitions and participation in many group projects. These activities fit into the larger plan:

Strengthening Existing Resources. At the onset, HSLCG members agreed to help each other by sharing resources. To do this, the members outlined interlibrary loan policies, exchanged surplus books and journals, and agreed to develop collections in certain specialty and subspecialty areas so that institutions could be designated as subject area resources.

Building New Collections. To assist in the development of book and journal collections in HSLCG libraries, the National Library of Medicine has awarded two Resource Improvement grants to HSLCG between 1977 and 1979.[3] A third application is presently under review. In several of the HSLCG libraries, the National Library of Medicine grant has provided the seed money for totally new library centers. In other libraries, resource bases have been broadened. In addition to the extremely helpful National Library of Medicine grants, the award of the Rotary Club's Mini-Medical Library Packs to three of our small hospitals has been a boon to these institutions.

Organizing for Accessibility. A union list of all the journal holdings at HSLCG member institutions is produced regularly. The initial list served as a guide to the location of the very limited health-related journal subscriptions then available in HSLCG libraries. The current and third edition of this union list of serials shows that the number of periodical resources available locally has more than doubled during the consortium's history. This growth is the result of the National Library of Medicine grants and the expanding membership.

Promoting Training and Continuing Education of Librarians. Simply by providing an opportunity for library managers to meet regularly, HSLCG has encouraged professional growth. The development of informal relationships among members allows exchange of ideas and has stimulated evaluation and improvements in library services. A more formal educational role is also assumed from time to time when the consortium sponsors workshops and programs relating to library management.

To implement these objectives and programs, an organization evolved that now provides the structure for the consortium.

HSLCG Governing and Financing

A consortium can be organized through a centralized office or in a decentralized manner. The centralized approach has the advantage of allowing continuous development over a comparatively short time span; an office can relieve the membership of many administrative tasks. A new feature in the National Library of Medicine's Resource Improvement Grant program brings the centralized approach within reach for many hospital library groups. The grant now provides for initial funding of a consortium librarian's salary.

When HSLCG was first organized it was unable to finance a consortium director and consequently evolved in a decentralized mode. In retrospect, the advantage of decentralization is clearly the promotion of a cohesive group. The decentralized organizational structure requires everyone to take a share in the start-up and, later, in the operational tasks. Today, HSLCG decentralization is complemented by a

circuit librarian consultation service that provides direct administrative assistance from one center to several smaller institutions.

Formal leadership for HSLCG is provided by the chairman and executive board, all elected annually. However, because of the comparatively small size of the membership, the decision-making process is a group activity. All members have a part in this through actions taken during meetings and in committee work.

To date, HSLCG operational costs have been absorbed by the members as part of the *quid pro quo* of membership. In order to insure a fairly equitable distribution of the costs incurred in HSLCG participation over the long run, cost data are collected from the members. Cost data from the last calendar year indicated that each member should contribute at least 50 to 60 hours to the consortium in the next 12-month period. These time units are in addition to travel and attendance at regular meetings.

Other Health Science Library Consortia in Georgia

Dr. Nicholas Davies, Chairman of the Small Hospital Library Project of the MAG, has urged Georgia health professionals to develop basic library or information centers in every hospital in the state within the next 10 years. The capabilities of these centers should be extended through a variety of networking approaches.[4]

At present, Georgia has five established library consortia, and several more networks are being planned. The first active consortium in the state, the Atlanta Health Science Library Consortium, serves that metropolitan area and includes a group of well-established libraries.[5] Because of its location, the group has ready access to a broad range of information resources. A second metropolitan-centered consortium is the Augusta Area Committee for Health Information Resources, which is experimenting with cooperation exclusively in the area of audiovisuals.

In addition to HSLCG, two other consortia serve primarily rural areas in Georgia. A consortium in south Georgia centers in Moultrie and includes five hospitals. The group shares medical library resources and provides information services under the direction of a circuit rider librarian. Another consortium, the Georgia Department of Human Resources Librarians Group, links the staff and patient libraries in 14 Department of Human Resources facilities, including 10 facilities outside the metropolitan Atlanta area. This group is made up primarily of medical/psychiatric and mental health/mental retardation collections.

The Future

Chronic information malnutrition need not be a terminal illness. It is amenable to therapy, but further delay in intervention will aggravate problems for the physician in terms of his continuing education and his delivery of quality patient care.

Hospital administrators are aware of the need for viable library services, and many are working to initiate these services in community hospitals. Physicians can suggest that grassroots consortia, developed in response to locally perceived needs, will provide a reasonable solution to current demands for health care information. The National Library of Medicine is facing the future by assisting in the funding of these local networks through its grant mechanism.

It appears that regulations will continue to add new requirements to the hospital operation. Library consortia can anticipate and respond to new standards for information services. Collective planning and cooperative programs are the surest means to identify and meet the challenges of the eighties.

References

1. Stoltz MD. Hospitals find libraries a 'must item' in budgets. Health Care Week 1978;1:13.

2. Joint Commission on Accreditation of Hospitals. Accreditation Manual for Hospitals. JCAH, Chicago, IL 1980;147-49.

3. PHS Grants 1 G07 LM03090-01 and 3 G07 LM03090-0151.

4. Davies N. The future of small hospital libraries. JMAG 1977;66:681-84.

5. Koplan SM, Chewning GJ, et al. Cooperative library services for Atlanta's hospitals. JMAG 1976;65:55-57.

PEACHTREE & PARKWOOD MENTAL HEALTH CENTER AND HOSPITALS



A private, comprehensive mental health center designed and staffed to meet the individual needs of patients by provision of a therapeutic milieu and the following specialized treatment programs:

ADULT PSYCHIATRIC PROGRAM

A plan that focuses on the particular requirements of the patient is drawn up by his or her personal psychiatrist. It includes, in addition to the milieu approach, group, recreational, horticultural and occupational therapy.

CHILD SERVICES

All types of psychiatric and learning disorders are treated with a multi-modality approach at this in-patient unit for children under 13 years of age. Out-patient services and a day-care program are an integral part of this service. All needed schooling is available.

ADOLESCENT PSYCHIATRIC PROGRAM

Includes a state-accredited special education middle and high school for patients ranging in age from 13 to 19 years. Patients participate in a milieu incorporating community identification, frequent interaction with staff members and individual appointments with psychiatrists.

ALCOHOL AND DRUG REHABILITATION PROGRAM

A comprehensive, individualized program of detoxification and rehabilitation is offered the alcohol and drug patient. Each patient works with a therapeutic team in planning treatment, and emphasis is on long-term out-patient follow-up.

MEDICAL SERVICES

A full-time staff of Board certified internists is available to meet the medical needs of all patients.

COMPLETE LAB COVERAGE AND RADIOLOGY SERVICE

Includes EKG, EEG, Isotope and fluoroscopic X-ray studies within the facility.

ADDITIONAL PROGRAMS AND SERVICES INCLUDE A DAY HOSPITAL PROGRAM AND AN OCCUPATIONAL MENTAL HEALTH SERVICES DEPARTMENT.

The Peachtree and Parkwood facilities are located on six tree-covered acres near the intersection of Briarcliff and North Druid Hills Roads in Atlanta. Complete information on services and facilities may be obtained by writing or calling:

PEACHTREE AND PARKWOOD

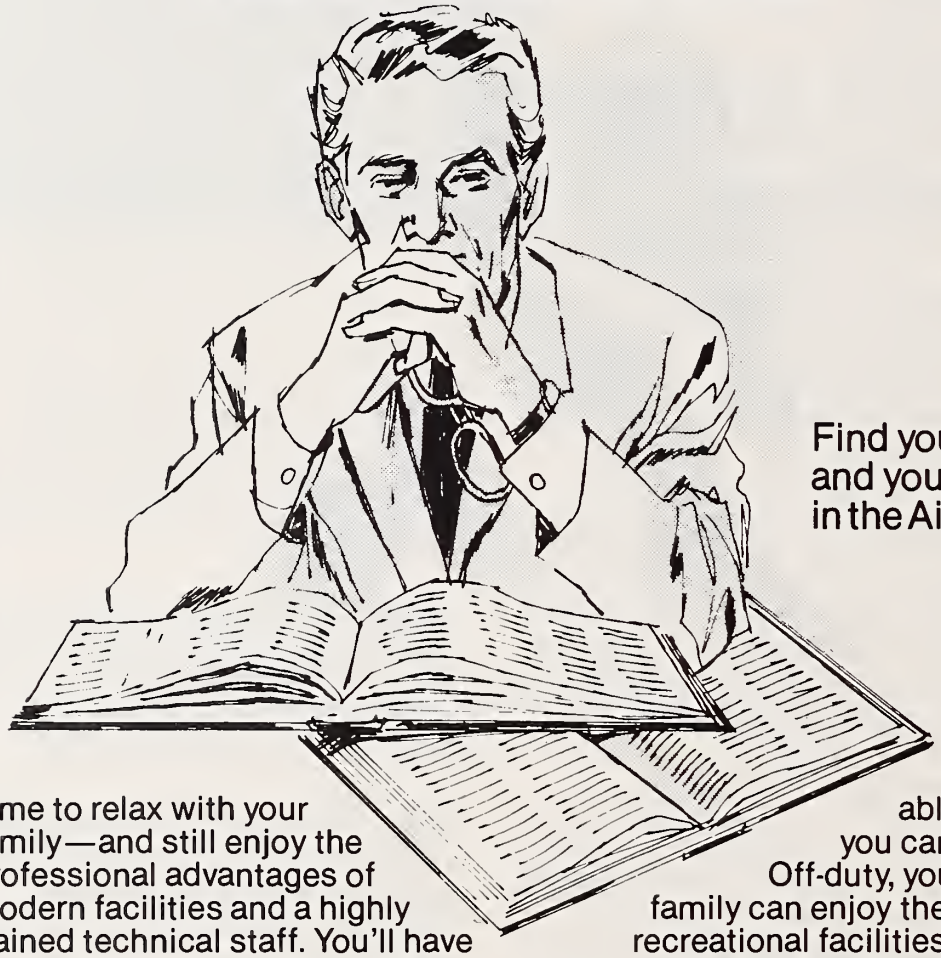
Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329
404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Be a Physician and a family man

There's time for both.



Find yourself... and your family in the Air Force!

Time to relax with your family—and still enjoy the professional advantages of modern facilities and a highly trained technical staff. You'll have the standing of an officer AND a professional. Yet, there's challenge, too. Air Force medicine ranges from research to every conceivable type of clinical practice, in every conceivable location you can imagine. Off-duty, you and your family can enjoy the excellent recreational facilities of the Air Force Base of your choice. One month vacation with pay... and many other extras. Health Profession Scholarships are available to medical students.

Find out more about your future in Air Force Medicine; we'll answer your questions promptly and without obligation. Contact:

Capt. Mike Gambino
612 Tinker St., Suite A
Marietta, GA 30060
(404) 427-5348 collect

AIR FORCE

A great way of life.

Culturing for* Campylobacter *should be a routine part of the laboratory examination of stools from patients with acute diarrhea.

Campylobacter fetus subspecies *jejuni* in Georgia

TIMOTHY J. BARRETT, PAUL A. BLAKE, M.D., *Atlanta* and DAVIE SWEET, *Gainesville**

Abstract

Campylobacter fetus subspecies *jejuni* was isolated from the stools of 5.6% of 124 Georgia patients with acute diarrheal illness. The isolation rate was highest in summer and declined markedly in winter.

Background

HUMAN INFECTION with *Campylobacter fetus* subspecies *jejuni* was described in 1957 by King, who called the bacterium "related vibrio" because of its similarity to *Vibrio fetus,* a well-known animal pathogen.[1, 2] King's isolates, as well as 12 others reported in the literature between 1961 and 1967,[3-6] were obtained from cultures of blood specimens. Dekeyser *et al.* first reported using a selective medium to isolate *C. fetus* ssp *jejuni* from stool in 1972.[7]

Studies by Butzler in 1973[8] and Skirrow in 1977[9] indicated that *C. fetus* ssp *jejuni* was a significant cause of diarrheal illness in Belgium and England, respectively. Since there had been no reports of *Campylobacter* isolation from stool in the United States, we undertook an investigation in July 1977 to determine whether *C. fetus* could be detected in the stools of persons in Georgia with diarrhea. Since this was a preliminary study designed only to determine whether *Campylobacter* could be isolated, no control groups were included.

Methods

The Northeast Georgia Medical Center in Gainesville and three private pediatric groups in the metropolitan Atlanta area participated in the investigation. When a stool was collected for culture from a patient with diarrheal illness, a cotton swab was dipped in the stool and then placed in a tube of cold Cary-Blair transport medium. Swab samples collected during the week were kept refrigerated until Friday, when they were transported in chilled containers to the Center for Disease Control (CDC) in Atlanta.

Each stool swab specimen was inoculated to a plating medium containing vancomycin (10 mg/l), polymyxin B (2500 I.U./l), and trimethoprim (5 mg/l) added to Oxoid Blood Agar Base No. 2† (Kansas City Biologicals, Lenexa, Kansas) with 7% lysed horse blood.[9] Plates were incubated at 43°C in a reduced oxygen atmosphere created by twice evacuating an anaerobic jar without catalyst and refilling each time with a gas mixture of 10% CO_2, 10% H_2, and 80% N_2. Plates were examined after 72 hours of incubation for the presence of colonies resembling *Campylobacter*. All isolates identified as *C. fetus* ssp *jejuni* were biochemically confirmed according to the criteria of Smibert.[13] Specimens that yielded *Campylobacter* were later examined for *Salmonella, Shigella,* pathogenic vibrios, enterotoxigenic and invasive *Escherichia coli,* and *Yersinia enterocolitica.*[14-17] Specimens were examined 3-7 days after they were collected.

* Mr. Barrett and Dr. Blake are from the Bacterial Diseases Division, Bureau of Epidemiology, Center for Disease Control, Public Health Service, Department of Health and Human Services, Atlanta, GA 30333; Ms. Sweet is from the Northeast Georgia Medical Center, Gainesville, GA. Address reprint requests to Dr. Blake.

† Use of trade names is for identification only and does not constitute endorsement by the Public Health Service, Department of Health and Human Services.

Results

C. fetus ssp *jejuni* was isolated from seven of 124 (5.6%) stool specimens from persons with diarrhea. This organism was isolated from 6 of 66 (9.1%) specimens collected in July-September and from only 1 of 58 (1.7%) specimens obtained in October-February ($p = .12$, Fisher's 2-tail exact test). *Campylobacter* was isolated from 5 of 87 (5.7%) stools collected in north Georgia and from 2 of 37 (5.4%) collected in the Atlanta area. No other bacterial pathogens were isolated from specimens which yielded *Campylobacter*.

Discussion

Since this investigation was carried out in 1977-1978, studies elsewhere in the United States have shown that *C. fetus* ssp *jejuni* is an important cause of diarrheal illness, including sporadic cases[18] and outbreaks.[10-12] The 5.6% isolation rate of *C. fetus* ssp *jejuni* from diarrheal stools is similar to the rates of 4.3% to 7.1% reported elsewhere.[9, 18-20] In at least one study, *Campylobacter* was found to be the most common bacterial pathogen isolated from persons with acute diarrhea.[18] We were unable to make such a comparison, since specimens were examined for other bacterial pathogens only after they were found to contain *Campylobacter*.

Our study results suggest that *Campylobacter* diarrhea is more prevalent in summer than in winter, although differences in isolation rates are not significant. Similar seasonal variation in the incidence of campylobacteriosis has been reported.[18, 19]

Since *Campylobacter* has been reported to be commonly associated with chickens and turkeys,[21] we examined the data to see whether the rate of isolation of *Campylobacter* from diarrheal stools in north Georgia, a major chicken farming region, was higher than the rate of isolation in metropolitan Atlanta. No significant difference was observed (5.7% in north Georgia versus 5.4% in Atlanta). This should not be interpreted as implying that *Campylobacter* is not poultry associated, however, as we do not have poultry-association histories on our patients.

Since no controls were included in our study, we cannot conclude that *C. fetus* ssp *jejuni* caused the illness of the persons from whom it was isolated. In other studies, however, the rate of isolation of the organism from well persons has been extremely low (0-1.3%).[9, 18, 19] Hence, our data suggest that *C. fetus* ssp *jejuni* may be an important cause of diarrheal illness in at least two areas of Georgia. Culturing for *Campylobacter* should be a routine part of the laboratory examination of stools from patients with acute diarrhea.

Acknowledgement

We are indebted to Mr. David Smith of the Georgia State Department of Human Resources, the staff of three DeKalb County pediatric groups, and the Northeast Georgia Medical Center for their assistance.

References

1. King EO. Human infections with *Vibrio fetus* and a closely related vibrio. J Infect Dis 1957;101:119-128.
2. King EO. The laboratory recognition of *Vibrio fetus* and a closely related vibrio isolated from cases of human vibriosis. Ann NY Acad Sci 1962;98:700-711.
3. Middelkamp JN, Wolf HA. Infections due to a "related" vibrio. J Pediat 1961;59:318-321.
4. Wheeler WE, Borchers J. Vibrionic enteritis in infants. Am J Dis Child 1961;101:60-66.
5. White WD. Human vibriosis. Indigenous cases in England. Br Med J 1961;2:283-287.
6. Darrell JN, Farrell BC, Mulligan RA. Case of human vibriosis. Br Med J 1967;2:287-289.
7. Dekeyser P, Gossuin-Detrain M, Butzler JP, Sternon J. Acute enteritis due to related vibrio: first positive stool cultures. J Infect Dis 1972;125:390-392.
8. Butzler JP, Dekeyser P, Detrain M, Dehaen F. Related vibrio in stools. J Pediat 1973;82:493-495.
9. Skirrow MB. *Campylobacter* enteritis: A "new" disease. Br Med J 1977;2:9-11.
10. Tiehan W, Vogt RL. Waterborne *Campylobacter* gastroenteritis — Vermont. Morbid Mortal Weekly Rep 1978;27:207.
11. Blaser MJ, Cravens J, Riepe P, Powers BW, Wang WL. *Campylobacter* enteritis — Colorado. Morbid Mortal Weekly Rep 1978;27:226-231.
12. Taylor PR, Weinstein WM, Bryner JH. *Campylobacter fetus* infection in human subjects: association with raw milk. Am J Med 1979;66:779-783.
13. Smibert RM. *Campylobacter* Sebald and Veron 1963, 807. In: Buchanan RE, Gibbons NE, eds. Bergey's manual of determinative bacteriology. 8th ed. Baltimore: The Williams and Wilkins Co., 1974;207-212.
14. Edwards PR, Ewing WH. Identification of enterobacteriaceae. Third Edition. Minneapolis: Burgess Publishing Company, 1972.
15. Feeley JC, Balows A. *Vibrio*. In: Lennette EH, Spaulding EH, Truant JP, eds. Manual of clinical microbiology, 2nd edition. Washington, DC: American Society for Microbiology 1974:238-245.
16. Morris GK, Feeley JC, Martin WT, Wells JG. Isolation and identification of *Yersinia enterocolitica*. Public Health Lab 1977;35:217-232.
17. Morris GK, Merson MH, Sack DA, Wells JG, Martin WT, DeWitt WE, Feeley JC, Sack RB, Bessudo DM. Laboratory investigation of diarrhea in travelers to Mexico: Evaluation of methods for detecting enterotoxigenic *Escherichia coli*. J Clin Micro 1976;3:486-495.
18. Blaser MJ, Berkowitz ID, LaForce FM, Cravens J, Reller LB, Wang WL. *Campylobacter* enteritis: Clinical and epidemiologic features. Ann Int Med 1979;91:179-185.
19. Lauwers S, DeBoeck M, Butzler JP. *Campylobacter* enteritis in Brussels. Lancet 1978;1:604-605.
20. Pai CH, Sorger S, Lackman L, Sinai RE, Marks MI. *Campylobacter* enteritis in children. J Pedatr 1979;94:589-591.
21. Lopez Brea M, Moline D, Baquero M. *Campylobacter* enteritis in Spain. Trans Roy Soc Trop Med Hyg 1979;73:474.
22. Simmons NA, Gibbs FJ. *Campylobacter* ssp in oven-ready poultry. J Infect 1979;1:159-162.

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

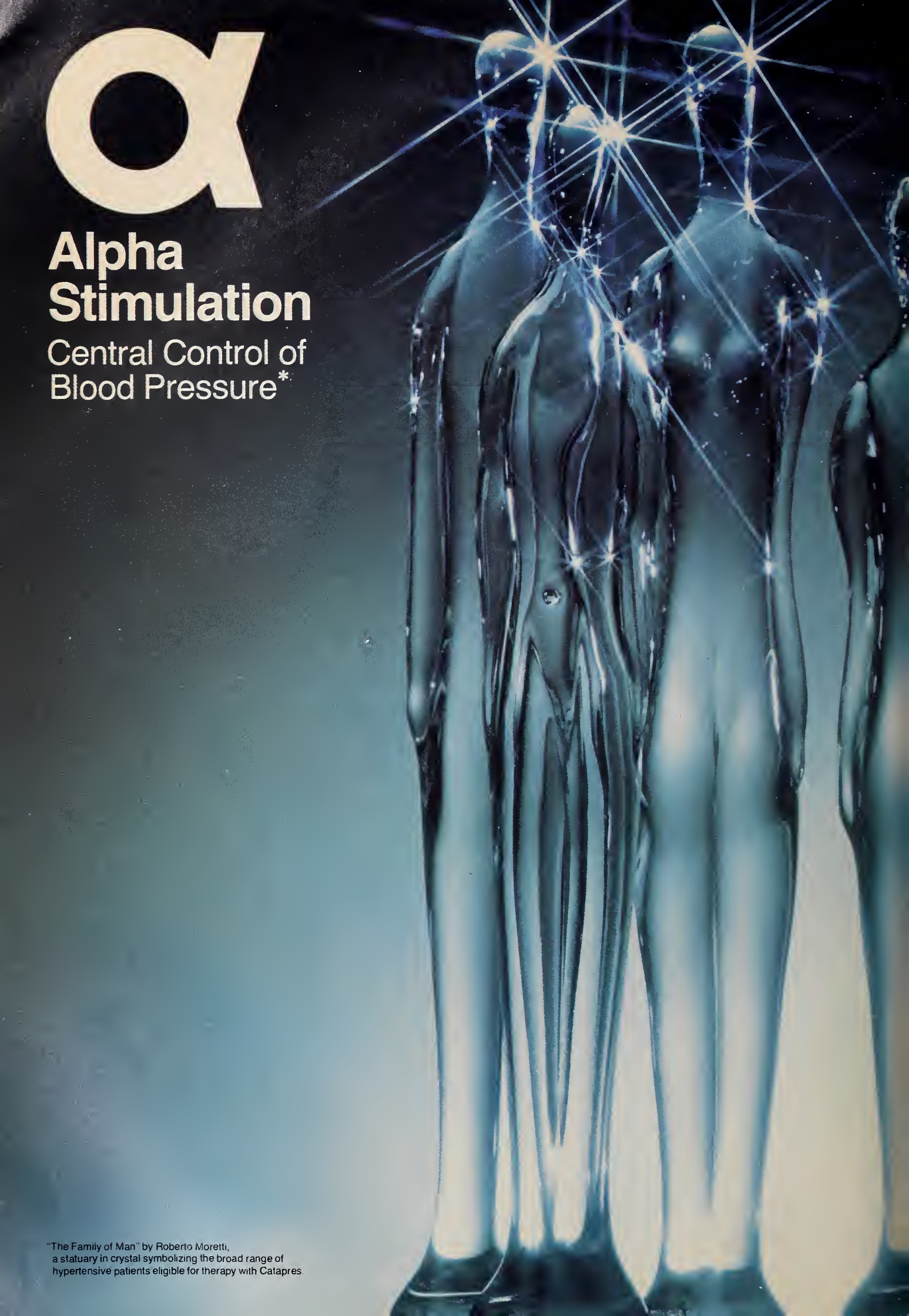
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products, Inc
Manati, Puerto Rico 00701

Alpha Stimulation

Central Control of Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

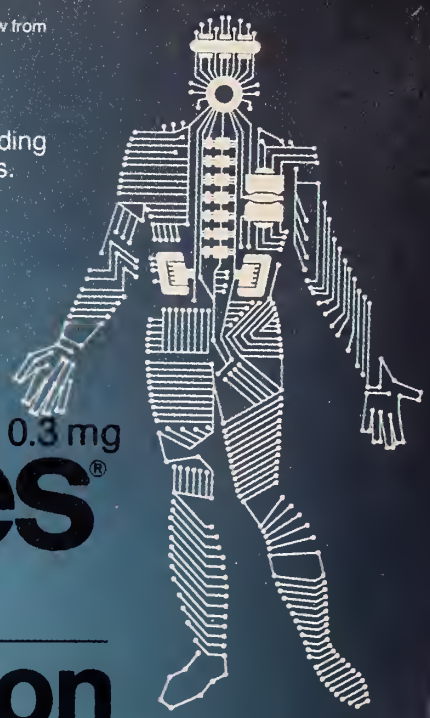
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets



Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension



The Alpha Advantage:

It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes: nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

Boehringer Ingelheim

Boehringer Ingelheim Ltd
Ridgefield, CT 06877

The author describes available alternatives to blood transfusions in the surgical treatment of this unique population.

Jehovah's Witnesses, How Can We Help Them?

M. M. FATTEH, M.D., *Augusta*

RELIGION IS AN IMPORTANT aspect of life. To most people, religion gives peace of mind, determination, and a feeling of gratitude. To achieve this, most people practice their religion at a level that does not seriously conflict with the pace or modernization of life. Some people, however, practice their religion at a greater depth involving a more literal interpretation of the Holy Book, and this can complicate their health and lives.

A literal interpretation of many biblical quotations prohibits the acceptance of a blood transfusion. Jehovah's Witnesses are a religious group whose members practice and adhere to this conviction rigidly. They are prepared to be tested to the limit, and in doing so they can endanger their lives. The religious feelings responsible for such determination deserve nothing less than great respect. For the medical community, however, this creates extremely difficult ethical and medico-legal problems.

Religious Background

For Jehovah's Witnesses, the evolution of the concept of not receiving transfusions of blood or blood components arose from a literal interpretation of several biblical quotations such as, "But flesh with life thereof, which is the blood thereof shall ye not eat,"[1] and "Moreover, ye shall eat no manner of blood, whether it be of fowl or of beast, in any of your dwellings. Whatsoever soul it be that eateth any manner of blood, even that soul shall be cut off from his people."[2] Whether the punishment means execution or excommunication remains a matter of individual interpretation. In any case, acceptance of blood is strongly condemned in many other biblical quotations.[3] Such mention is made in both Mosaic and Christian law. From the literal interpretations of all these quotations, it becomes clear that the people who believe and strongly adhere to these beliefs think that it is God's (Jehovah's) law commanding abstention from blood transfusions. It must be understood that this is not their personal whim, and, therefore, the medical community must respect it. The Witnesses feel that obedience to God is tested to the limit, and they are determined to meet the test.

Medico-Legal Aspects

A patient has the right to withhold his consent to lifesaving measures,[4] including a blood transfusion. Given this fact and considering the beliefs of Jehovah's Witnesses, this raises interesting and puzzling medico-legal questions. Could a doctor be held responsible if blood is not given to a Jehovah's Witness? According to Judge Warren Berger, Chief Justice of the U.S. Supreme Court,[5] a doctor might not be held responsible for not transfusing blood if a waiver is signed by the conscious, well-oriented, adult patient. The issue of minors, however, is more difficult to resolve. Children under 12 are considered incapable of giving informed consent, and, therefore, parental consent is required. In the absence of parents, one could obtain a court order if state law permits. "Absence" refers to both the inability to contact parents in time or the nonexistence of parents. In the case of the emancipated minor, however (defined as one between 12 and 18 years of age in most states), one has to be extremely careful in the event of differing viewpoints between the parents themselves. In such situations, legal help should be sought if time permits.

* Dr. Fatteh is Director of the Blood Bank, Medical College of Georgia, Augusta, GA 30912.

Ethical-Legal Issues

A physician knowingly administering blood to a Jehovah's Witness patient without informing him of this could be legally liable.[5] According to Dr. William P. Williamson at the First National Congress on Medical Ethics and Professionalism, "Life is the gift of the Creator to the individual, and the individual is the custodian of that gift." The physician should treat the patient within the dictates of the patient's religion and not force his own convictions upon him. To do otherwise is legally and ethically unacceptable, but it is also ineffective in the treatment of the "whole man."[6] Treating an unwilling Witness patient with a blood transfusion may alleviate physical problems but might cause serious emotional and psychological disturbances that could persist for a lifetime. Therefore, in the long run, it would do more harm than good.

How Do You Identify a Jehovah's Witness?

In non-emergency situations, most Jehovah's Witnesses volunteer the information about their beliefs and are also willing to sign a statement to that effect. An unconscious Witness, however, not accompanied by relatives or friends can pose perplexing difficulties. Many Jehovah's Witnesses carry a signed card in their wallets which states their religious beliefs regarding blood transfusions and indicates their willingness to accept personal responsibility for these beliefs. An emergency room staff person might find such a card accidentally while searching the wallet of an unconscious Witness patient for other information. The other side of the card shows types of fluids which are allowed to be infused into such patients. It also gives some biblical references. A doctor or hospital might not be held liable if blood is not given in this situation.[7]

Although their religious doctrine demands strict abstention from blood, there is slight variation in acceptance of this conviction. Based on personal communications, I have broadly categorized three classes of Jehovah's Witnesses: (A) Those who are willing to accept their own blood (autologous transfusion) for elective surgery as well as artificial blood; (B) Those who do not believe in accepting their own blood (autologous transfusion) for elective surgery but who will accept synthetic blood; and (C) Those who refuse both autologous and artificial blood transfusions.

Group A patients are obviously the easiest to treat. Group B patients are more difficult to treat at present, although they may be helped when better success with artificial blood has been achieved. Group C patients are the most difficult to treat not only because of their refusal to accept artificial blood but also because they feel that the development of synthetic blood has put tremendous pressure on them. Some feel that they are being used as guinea pigs for such experiments, especially since the safety and effectiveness of this new drug have not yet been established.

How Can Physicians Help Them?

As stated earlier, a patient has the right to withhold his consent to lifesaving measures.[4] Whether we as physicians like this or not, we have to accept it. Yet, blood transfusion is just one facet of therapy. A physician may not refuse to treat a patient who does not accept his personal convictions in a life-threatening situation. He is morally, ethically, and legally obligated to provide the remaining facets of the medical care, whatever those may be.

Autologous Transfusion

Acceptance of this mode of therapy by the Jehovah's Witness patient minimizes the difficulties for elective surgery. However, most Jehovah's Witnesses are at first unsure as to whether they may accept this mode of therapy and often, after consulting with more experienced Witnesses or interpreting the Bible quotation more literally, decide that they may not. Unfortunately, the number that are willing to accept autologous transfusion is very small. If a Witness is willing to accept autologous blood for elective surgery, however, such a person can be helped a great deal, depending on the nature of the operation and the volume of blood or blood components required. The following blood components could be useful:

A. Autologous whole blood collected in Citrate-Phosphate-Dextrose (CPD): Usable for 21 days.
B. Autologous whole blood collected CPD-Adenine (CPD-A): Usable for 35 days.
C. Autologous whole blood collected by "leap-frogging" technique. Five units collected in CPD or CPD-A: Usable for 21 and 35 days, respectively.
D. Frozen blood: Can be stored for several years.
E. Autologous frozen plasma — can be stored for 1-2 years.
F. Autologous frozen platelets (procedures not available in all centers)

Not all of the above mentioned products are available in every hospital. The need for the particular product would depend upon the nature of the surgery and the amount of blood loss anticipated. Collection of five units of whole blood through the "leap frog" technique takes approximately 1 month. The distinct advantage is that all units are less than 2 weeks old. If such blood is collected in the anticoagulant CPD-A, the oldest unit can be stored up to three additional weeks after all units have been collected. Two of the five units are fresh and can be stored up to 5 weeks in the CPD-A.

"Bloodless" Surgery

The issue of Jehovah's Witnesses not accepting blood transfusions required some surgeons to try "bloodless" major surgeries on these patients, where the benefits of success outweighed the risks of not operating. Following this, these techniques were tried in elective surgeries on Jehovah's Witness and non-Jehovah's Witness patients. In the latter group, however, blood was kept available for an emergency but was rarely used. There have been many claims of success, even for such major operations as open heart surgery.[8] Information on such procedures is available through a "hotline," (714) 751-4554, in Santa Ana, California. Of course the risk of bloodless surgery depends upon the complexity of the individual case. One would think that in expert hands there is a fair chance of success without a transfusion.

Artificial Blood (Fluosol DA 20%)

Artificial blood, or Fluosol DA 20%, is a fluid of perflurocarbons with other essential additives such as glucose, Kcl, $MgCl_2$, $CaCl_2$, $NaHCO_3$, glycerol, NaCl, hydroxyl ethyl starch, and yolk phospholipids.[9] In animal experiments, some complications such as thrombocytopenia, hypoxia, and DIC-like lesions were identified, but in healthy human volunteers and sick patients, such complications have not been observed. This fluid is an excellent oxygen transport medium and has not been found to be toxic to humans. It does, however, have a short half-life of only 4-6 hours, which could be one of the major drawbacks to its use. Thus far, information derived from human experiments is too small to allow any speculation as to whether this would be a successful fluid even for short-term emergency therapy.

Fluosol DA 20% has received much undeserved publicity. It has not conclusively been proven safe or effective and since it is still an experimental drug, it is not licensed by the FDA. Although it has been tried in several patients in the United States, detailed scientific data are not yet available. Some experts anticipate that it will take 5-10 years to gain FDA approval if it is found to be successful, since information is so meager.[10] Arrangement for the infusion of this drug requires the approval of both the FDA and the research team of Alpha Therapeutics Company located in Los Angeles, California, who are involved and remain with the patient. Because of these circumstances, Fluosol DA 20% is not available for emergency transfusion and may only be considered for use in elective surgery with postoperative complications if prior arrangements have been made.

If Fluosol DA 20% proves to be an effective and non-toxic, oxygen-transport medium, however, it has tremendous potential despite its short half-life.[11] It could be used in ambulance emergency kits, since it does not require crossmatching. It could also be given to patients with sickle cell anemia undergoing surgery to maintain high oxygen levels and thus would prevent sickling of the red cells. Repeated infusions with such a fluid would not lead to the antibody formation that takes place after repeated red cell transfusion, an advantage to patients with disorders such as aplastic anemia. In cases with partial occlusion of vessels due to thrombosis, this fluid might have an advantage over red cells, since it can carry oxygen more easily to perfuse the ischemic area. Fluosol DA 20% also has multiple potential uses in experimental research, one of them being organ preservation. Although artificial blood has received tremendous publicity lately, it is really not a new drug. Flurocarbons have been tried in some early animal experiments. Only recently, however, have they been tried in human volunteers and patients.[12] This fluid does not have platelets, white cells, coagulation proteins, and immunoglobins that whole blood and blood components have. It possesses only one of the many important qualities that human blood possesses — the ability to transport oxygen.

Summary

From a medical standpoint, Jehovah's Witnesses pose a challenge to physicians, who might feel frustrated in advising them regarding surgery unless they have definite information on the available alternatives to blood transfusions: bloodless surgery, plasma expanders, autologous transfusion, and maybe in the future, artificial blood. Physicians also need to be aware of the medico-legal implications of the decisions they make in different situations.

References

1. Bible. Genesis 9:4.
2. Bible. Leviticus 7:26, 27.
3. Bible. Acts 15:20, 28, 29; Leviticus 3:17; 1 Chronicles 11:19.
4. Medico-legal forms with legal analysis. Office of General Counsel, 1976;24,38.
5. Gardner B, Bivona J, Alfonso A, Herbsman HH. Major surgery in Jehovah's Witnesses. NY State J Med. May 1975;765-767.
6. Cesberg MA. The patient as a "whole man." JAMA July 3, 1967;150.
7. Berger W. University of San Francisco Law Review. 1975;28.
8. Roche J, Stemple J. Need for blood in open heart surgery. JAMA Dec. 1973;1230-1231.
9. Sloviter H. Perfluro compounds as artificial erythrocytes. Federal Proceedings. May 1975;1484-1487.
10. AABB Recent Artificial Blood Policy. AABB News Release, Feb. 1, 1980.
11. Geyer R. Potential uses of artificial blood substitute. Federal Proceedings, May 1975;1525-1528.
12. Ohyanagi H, Toshima K, Sekita M, Okamoto M, Itoh T, Mitsuno T. Clinical studies of perflurochemicals whole blood substitutes. Safety of Fluosol DA 20% in normal human volunteers. Clin Therapeu 1979;2(4):306.

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

Serving the General Insurance needs of
the Medical Profession for 60 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite
Charles E. Malmquist

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Some of the world's
best-dressed men wear the Guffey's label.



Guffey's: A holiday tradition
for the best man on your gift list.

Guffey's
OF ATLANTA
Clothing for Men in Taste and Tradition

Peachtree Center
(Behind the Sculpture)
230 Peachtree Street, N.E.
404-522-0044

Tower Place
(At Piedmont Entrance)
3340 Peachtree Road, N.E.
404-231-0044
Ample Free Parking


Have a Coke®
and a smile.
Coke® adds life.
registered trade-marks which identify the same product of The Coca-Cola Company.

editorial
editorial
editorial

Correcting a Bad Impression

God's reputation was at stake. He had worked for many centuries trying to give man a clear picture of Himself. Somehow the whole thing got off to a bad start. That is what the story in the beginning of Genesis is all about, and the whole Bible traces a series of events and stories of how man bought a false image of God. In the very beginning, the serpent suggested that God was hiding something good from Adam and Eve. The snake encouraged them to rise up and take over. It was through this initial false image of God that the trouble began.

The prophets were sent to straighten out this bad impression. Amos, Hosea, and Jeremiah all tried to help the people see what God was really like. Occasionally, a glimpse did come through. The high points in Old Testament literature are thrilling to read because they contain a brief and startling picture of the true nature of our Creator, but in a short time the image was confused. The true view of God was clouded, and people reverted to making God in their own image.

It has always been the most fundamental heresy in religion — and it continues to be a problem today — that of building an image of God to suit our own needs. How does God go about correcting a bad impression? Christmas is His answer.

If the Christmas story is true, it forever solves the problem for man as to what God is really like. **All we need to know about God is revealed to us in His taking on flesh in order that we might see Him and know Him.** If I want a small child to know me better, I need to get down on the floor where the child plays. If I want my teenager to know me better, I need to get into that teenager's world. In theology, Christmas is called the Incarnation (infleshment). **None of us is ever intimately known by another until he is willing to move into the other's world and make himself vulnerable to that world.** I cannot play on the floor without getting dirty. I cannot involve myself in the youth culture without listening to the loud music. Though He tried throughout the centuries of Old Testament history, God could not reveal Himself to us fully without taking on our flesh.

Christmas asserts that we have been wrong all along about the true nature of God. **The most prevalent heresy today, as in ages past, is creating an image of God which fits our selfish needs. Christmas demands that we look at Jesus and how He lived if we want to know how God expects us to live.** It is God's dramatic act in history to correct the bad impressions we have held. The joy of gift giving, of family time, and happy memories all pale beside the awesome event of God making Himself known to us. The serpent was wrong. Jesus came to undo all false concepts and images that had built up through the centuries. Those false notions are still with us today; so we need this year, as every year, the celebration that reminds us again what God is really like.

Daniel P. Matthews
Rector
St. Luke's Episcopal Church
435 Peachtree Street, NE
Atlanta, Georgia 30365

AMA — Atlanta — MAG
Winter Scientific Meeting

January 24-26, 1981
Atlanta Hilton Hotel

On the last weekend of January, 1981, we will be privileged to have the 34th AMA Scientific Meeting at the Atlanta Hilton. Now called the "Winter Scientific Meeting," this meeting marks the evolution of the old "AMA Clinical Meeting," held for years as part of the annual AMA meeting, and then in 1979 presented separately at a different time as a purely educational-scientific meeting, much in the same manner as the MAG Annual Session and the MAG Scientific Session have been separated.

Beginning in 1979, the first Winter Scientific Meeting was held in Miami, last January in San Antonio, and now in 1981 in Atlanta. Atlanta is certainly on the circuit for meetings and reportedly the second or third busiest convention center in the United States. This affords us physicians in the Southeast, and in Georgia particularly, great opportunities for continuing medical education, close at hand, and with little expenditure of time or money.

I have particularly enjoyed the opportunity, as Program Director for the meeting, in working with the distinguished members of the AMA Council on Continuing Physician Education, with Richard Bergland, M.D., of Boston, as Chairman; and with the pros in the AMA Department of Scientific Assembly, with Richard Myers, Director. We have had marvelous cooperation from the deans of the Medical College of Georgia, Emory University School of Medicine, University of Florida Health Center, University of Alabama School of Medicine, and the Medical University of South Carolina in obtaining a distinguished faculty. The co-sponsoring specialty societies have offered their usual outstanding support in formulating sections of the program.

All in all you are presented with a veritable smorgasbord of educational opportunity. You may design your schedule to fit your particular needs, whether it be in-depth review and update in a particular area of interest, or whether you desire a broader selection from a wider variety of clinical interests. There is tremendous flexibility available. In a long weekend, you may pick and choose to suit your needs and your schedule. Take the time now to review the offerings and make your schedule and your reservations.

As you will see, there are distinguished lecturers, postgraduate courses, update workshops, poster sessions, etc. Your spouses will enjoy many of the presentations, and in addition there is a separate schedule of auxiliary activities. The noon hour "distinguished lecturers" should challenge you with these topics: "Endorphins and Beyond — The Future of Brain Hormones in Clinical Medicine;" Different Approaches to Cost Containment;" "Does the Dawn of Genetic Engineering Herald a Golden Age of Medicine?".

At an early hour each day we will be presented with such stimulating topics as "Problems Facing American Medicine;" "Problems Facing The American Family;" "Update on Cardiac Disease;" "Surgical Aspects of GI Disease" — each presented by an outstanding authority in the field. On Sunday morning a challenging discussion of "Fibrocystic Disease of the Breast — Forerunner of Breast CA" will be offered.

The three days will be time well spent. The meeting is close at hand. The program is fully accredited for Category One. Come and see the AMA wearing another of its many hats as a provider of excellent continuing education for practicing physicians.

I hope to see you all in Atlanta at the Hilton in late January, 1981.

LaMar S. McGinnis, M.D.
Program Director

Facility Fees — To Be or Not To Be

In March, 1980, the Georgia General Assembly passed Senate Bill (SB) 217, which was sponsored by Senator Richard Greene of Macon and strongly supported by the Medical Association of Georgia. SB 217 amended Code Section 56-3016 of Georgia law by adding subsection (c) at the end of the Act. This amendment mandated that insurance companies carrying medical or surgical policies on individuals for accident and sickness reimburse physicians for services performed on an out-patient basis at the same rate as they were reimbursed for similar procedures covered on an in-patient basis at a licensed hospital.

The purpose of SB 217 was to encourage the use of out-patient facilities for those procedures that could be done just as safely and effectively as in a hospital. This would result in a reduction in the overall cost of medical care by reducing costs from a $600.00 to $1,200.00 hospitalization expense and a physician's fee of perhaps $50.00 to $200.00 to simply the physician's fee plus ancillary or facility costs. These would include the cost of the operating room, surgical trays, bandages, laboratory charges, and/or drugs, etc. These facility fees associated with operations done in a doctor's office are usually equal to, or less than, similar charges made by the hospital, while the hospital bed expense would be non-existent.

In order to have an accurate and up-to-date list of out-patient operative procedures, MAG's Peer Review Committee recently evaluated the list of Ambulatory Surgical Procedures as endorsed by Blue Shield of California. Each specialty society representative took back to his specialty society the pertinent list of procedures, using the number and terminology as is given in the *Physician's Current Procedural Terminology* (CPT), 4th edition, published by the American Medical Association. Each specialty society then submitted, or will submit, its updated appropriate list of procedures for inclusion in SB 217 to the MAG.

SB 217, which became effective on Sept. 1, 1980, was referred to the Georgia Attorney General, Arthur K. Bolton, for interpretation on two points: (1) whether the facility fees are covered by the bill, and (2) whether such procedures are to be reimbursable if performed by dentists. **Unfortunately, the answer to coverage of facility fees, one of the primary reasons for SB 217 in the first place, was no.** Dentists may carry out such procedures, but not in their offices, as this specific language was not in SB 217.

Practically, the additional facility fee may amount to perhaps $20.00 to $150.00 which the patient will now have to pay out of his pocket if the procedure is done on an out-patient basis. Many patients may choose a 1-3 day hospitalization, where they would not have any out-of-pocket expenses, rather than submit to an out-patient operative procedure which would cost them $20.00 to $150.00, thus defeating the intent of the original bill.

Indeed, the surgeon really prefers to do out-patient procedures when they can be safely and effectively performed, as the physician's time is more efficiently utilized for the same operation in an out-patient setting. He may, indeed, submit a professional fee $20.00 to $50.00 less than his usual hospital charge for the same surgery. Although the patient would generally prefer out-patient surgery, if he has to pay the facility fees out of his own pocket, as is now necessary under SB 217, he will opt for hospitalization, thus leaving the Georgia physician in the same position now as before SB 217 was passed.

On September 24, 1980, the Budget Reconciliation Conference of the U.S. House and Senate considered and agreed to have drawn up a federal bill which, if passed, would have similar language as Georgia SB 217, except that it would authorize reimbursement at 100% for the facility fees performed on an out-patient basis on Medicare or Medicaid claims. The federal bill will also require that the surgeon must be on the staff of an accredited hospital with privileges to perform the same procedures in the hospital, and he must be agreeable to have PSRO peer review monitoring of his services. This bill will be considered during the 1980 "lame duck" session of Congress.

We now have two alternatives in Georgia concerning reimbursement of facility fees by third parties: (1) to seek legal challenge to the Attorney General's ruling, or (2) to develop a bill in Georgia to be modeled after the national Medicare and Medicaid bill under consideration in Washington. With the two safeguards mentioned above incorporated in a new Georgia bill, in conjunction with the proposed planned national bill, the likelihood of abuse of out-patient surgery will be significantly lessened. Encouragement of your senators and representatives concern in this area will be important now in insuring consideration and passage of such a bill.

Walter S. Dunbar, M.D., Chairman, MAG Peer Review Committee
384 Peachtree St., N.E., Ste. 1210, Atlanta, GA 30308



SOME MALPRACTICE INSURANCE POLICIES SETTLE FOR JUST ANYBODY.

Today, all too many people are finding it easy to sue. And unfortunately, all too many insurance companies are finding it easier on themselves to settle. Quickly and out of court. Little thought is given to defending your reputation.

In fact, your insurance company may not even give you an option to fight a claim. Or if you do have that option, you can be hit with a costly penalty for going to court.

And there are other ways your insurance company may not stand behind you. For instance, chances are to save costs and time your company will use a claims adjuster to handle your case. Not a lawyer.

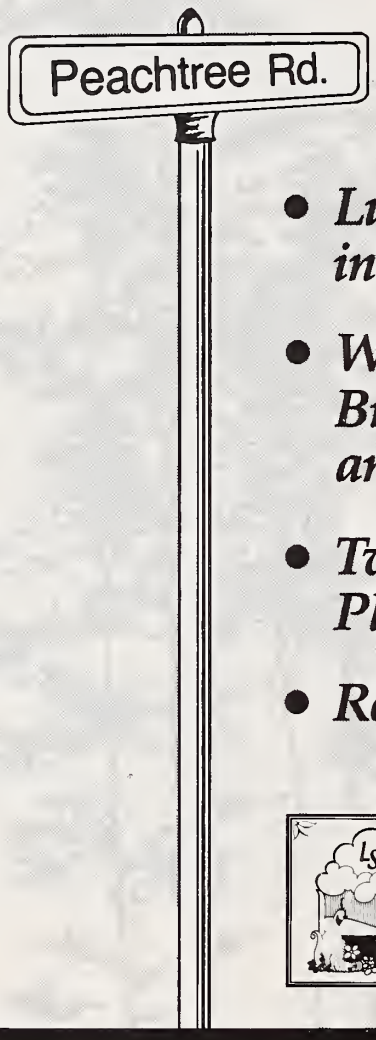
It's a different story at Insurance Corporation of America. ICA is a doctor and attorney owned company working hard for doctors. We know the strong coverage and knowledgeable service physicians need from their liability insurance. And because we specialize in this one field, we can offer a superior policy at a realistic premium. Premiums based on actual costs in your state.

Don't settle for just any insurance. Get a policy that really stands behind you. Contact: Insurance Corporation of America, ICA Building, 2205 Montrose, Houston, Texas 77006. 713-526-4863. Outside Texas phone 1-800-231-2615.

ICA INSURANCE CORPORATION OF AMERICA

MALPRACTICE INSURANCE IS BETTER TODAY. BECAUSE OF ICA.

Your Retirement Residence Will Soon Be On This Street



- *Luxurious accommodations in a new 23-story building*
- *Within one mile of the Brookhaven Country Club and the Standard Club*
- *Two minutes from Phipps Plaza and Lenox Square*
- *Refundable Entrance Fee*

Lenbrook Square

Write or Call: John Pettit or Jack Clark
Lenbrook Properties • 10th Floor — Lenox Towers
Dept. ME • 3390 Peachtree Road
Atlanta, GA 30326 • 404 / 233-3000

Dealing With Formal and Informal Requests From Attorneys for Production of Patient Records in Connection With Civil Litigation

ROBERT N. BERG, *Atlanta**

One of the occupational hazards which the modern day physician must face is the necessity of dealing with requests from attorneys for the production of patient records which the physician has prepared. As I am sure each of you is aware, the patient records which you prepare are often times relevant, and, in some instances, even critical, to the prosecution or defense of personal injury and other similar lawsuits. In that regard, we have in the past written articles[1] concerning the legal and practical problems with which the physician may be confronted in connection with requests for production of patient records. However, in light of recent statutory amendments in Georgia dealing with the production of documents by persons other than those involved in the lawsuit (i.e., "non-parties"),[2] and with the creation of immunity from liability to physicians releasing patient records and information upon proper authorization,[3] we believe that it is an appropriate time to update our previous discussions concerning this topic.

In a typical situation, a physician will receive an informal request, usually in writing, from an attorney representing one of the litigants involved in a personal injury-type lawsuit. The request will in most cases ask that the physician produce, voluntarily, the records which he or she has prepared concerning the patient. Although the records are not privileged (since Georgia, unlike many states, does not have a general privilege with respect to physician-patient communications[4]), these records are usually of a confidential nature. In some instances, the written request may go so far as to cite the applicable provision of the **Georgia Code, *Ga. Code Ann.* §81A-134(c),** which authorizes the attorney to make the request to produce. **By no means, however, does this Section flatly *mandate* that the physician produce the requested documents;** rather, this Section simply sets out the procedure by which the physician, as a non-party, along with the parties to the lawsuit, can deal with the touchy subject of the production (or, in appropriate cases, the prohibition or protection against production) of confidential patient records.

Section 81A-134 is part of the Georgia Civil Practice Act[5] and is designed to deal with the production of documents. This Section is divided into three parts: **subsection (a), which sets out the scope of the right of a party** to a lawsuit to request document production from any other party to the litigation; **subsection (b),** which **sets out the procedure for making such a request;** and **subsection (c),** which **applies the provisions of subsections (a) and (b)** to requests for production made **by non-parties.** It is this latter subsection that authorizes requests for documents such as a patient records from non-parties such as physicians.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30335.

As set out in Section 81A-134, the party (or his or her attorney) **requesting the documents must serve a written request on the non-party,** setting forth the items or documents to be produced, either by individual item or category, and describing each item and category with reasonable particularity. The non-party then has thirty (30) days from the date of service of the request within which to object in writing to any one or more item or category of documents. Subsequently, the party submitting the request to produce, upon receiving an objection to such request, has the right to move for a court order requiring production of the requested documents. **This motion for a court order must be accompanied by a showing of good cause in support of such order.**

Were it not for the confidential nature of the patient records, it is likely that the physician, as a law-abiding and conscientious citizen, would produce the documents and patient records upon request. It is not quite that simple, however, in light of the fact that the patient involved may not wish the documents to be disclosed. More importantly, if the physician chooses to comply with the request to produce without first consulting with the patient, the patient may seek to vent his or her anger against the physician by way of instituting a lawsuit against the physician claiming that the production of documents constituted a violation of the patient's right of privacy.

In order specifically to deal with this situation, the Georgia legislature passed *Ga. Code Ann.* §38-418(b). Although this Section is not a model of legislative clarity, it does provide that **in cases where a physician releases medical information concerning a patient upon the proper written authorization of the patient,** his or her legal representative, or upon court order or subpoena, **the physician shall not be liable to the patient or any other person.** In other words, if the physician obtains the written authorization from the patient sanctioning the release of that patient's records, or if the physician is ordered to produce these documents by a subpoena or by a specific court order, then the physician will not be liable to the patient or anyone else for violating the patient's right or privacy.

How does this Section fit in with the statutory provisions described above concerning the party to a lawsuit's right to request the production of documents from a non-party? It appears that these two Sections fit together quite nicely.

For example, **when a physician receives an informal written request from an attorney to produce patient records,** the physician could first suggest to the attorney that the attorney obtain the written consent or waiver of the patient; by doing so, the attorney could obtain the patient records which he desired, while the physician could insure himself or herself of obtaining the protection of Section 38-418(b). Failing to receive this written authorization, the physician could then object to the request in a timely fashion and in writing, to the extent that the request involved the production of potentially-confidential patient records. Thereafter, the party making the request could, as authorized in Section 81A-134, move for a court order compelling production of the documents. This procedure would both require that party to show good cause as to why the documents were necessary, and afford to the patient/party the opportunity to preserve the confidentiality of the documents by arguing against the motion to compel. If the patient were to succeed in this argument, then the physician would not be required to comply with the request to produce. More importantly, if the court were to grant the motion to produce and require that the physician produce the patient records, the prerequisite of Section 38-418(b) (that the production of information be made only upon court order or subpoena) will have been met, and the physician will be protected against civil or criminal liability arising as a result of the "mandatory" production of those patient records.

Rather than utilizing an informal written request in order to obtain patient records, attorneys may in some instances opt for the more formal procedure of obtaining and delivering to the physician a subpoena issued by the clerk of the court. This procedure is authorized by *Ga. Code Ann.* §38-801, which provides that a subpoena may be issued commanding that the person to whom it is directed

produce the books, papers, documents or tangible things designated in the subpoena. Unlike the situation involving informal written requests, where the physician is authorized to make objections to the request directly to the requesting attorney, the physician receiving a subpoena may object only by filing a written motion with the court; this motion must be made "promptly and in any event at or before the time specified in the subpoena for compliance therewith."[6] It is then up to the court to either (1) quash or modify the subpoena if it is unreasonable and oppressive, (2) deny the motion to quash and require production of the documents, or (3) deny the motion to quash on the condition that the person on whose behalf the subpoena is issued advance the reasonable costs of production of the documents.[7]

In terms of possible exposure to liability, the physician receiving the subpoena, following the procedure outlined above, should be protected to the same extent as the physician receiving the informal request to produce. If the court determines that the subpoena should be quashed, then the physician would obviously not have any exposure to liability. On the other hand, if the court determines that the subpoena should be obeyed, then the physician may do so under the protective umbrella of Section 38-418(b) since the production of patient records by the physician is pursuant to a subpoena.

One note of caution in connection with the physician's initial refusal to produce the patient's records. Although it is by no means certain, it appears that an argument could be made under Section 81A-137 of the Georgia Code that, in cases where the court ultimately ruled in favor of the person requesting production of documents, the physician could be required by the court to pay the court costs, attorney's fees and other reasonable expenses incurred by the party in obtaining the order compelling production. In such cases, however, it would be up to the moving party to show that the physician's opposition to the motion to compel was not "substantially justified" or that there were not "other circumstances to make an award of expenses unjust."

This argument has not to our knowledge been successfully asserted by a party to a lawsuit against a physician or other non-party, nor is it certain that a court would ultimately grant such a motion against a non-party, in that **Section 81A-137 expressly deals with the payment of expenses by the *losing* party.** In any event, the risk of paying court costs and attorney's fees could be minimized by the physician, in that documents which were obviously not of a confidential nature could be produced by the physician to the requesting party, thus showing that the physician was acting in good faith. Moreover, the relatively remote risk of paying court costs and attorney's fees is certainly outweighed by the protection available to the physician in cases where he or she satisfies the prerequisite of Section 38-418(b) and obtains the shield of that Section's protection against liability.

Notes

1. See e.g., Vincent RH. Civil litigation: physicians' rights and obligations in producing patients records for discovery purposes. JMAG 1978; 67(1):69.
2. Acts 1979, Page 1041, effective April 16, 1979, amending *Ga. Code Ann.* §81-134(c).
3. Acts 1978, Page 1657, effective July 1, 1978, amending *Ga. Code Ann.* §38-118.
4. See generally 81 *Am. Jur.* 2d, "Witnesses," §230; c.f. *Ga. Code Ann.* §38-418(a).
5. *Ga. Code Ann.* §§81A-101 *et seq.*
6. *Ga. Code Ann.* §38-801(b).
7. *Ibid.*

Psychiatric Institute of Atlanta

Specialized Health Care in the Heart of Atlanta



Neuropsychiatric Evaluation Unit
Adult Psychiatric Program
Alcohol Detoxification Program
Short-term Adolescent Treatment Program

811 Juniper St. NE, Atlanta, Ga. 30308 • 873-6151

TEGA-VERT CAPSULES

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

Each capsule contains:

Pentylenetetrazol (Metrazol)	50 mg.
Niacin (Nicotinic Acid)	50 mg.
Dimenhydrinate (Dramamine)	25 mg.

ADMINISTRATION & DOSAGE: One or two capsules three or four times daily before or after meals.

INDICATIONS: TEGA-VERT is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: TEGA-VERT should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

ORTEGA PRODUCTS ARE DESIGNED WITH THE FAMILY PHYSICIAN IN MIND

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC. — JACKSONVILLE, FLORIDA 32205

Recommendations for Phonocardiography

BARRY D. SILVERMAN, M.D., *Atlanta**

PHONOCARDIOGRAPHY is used to (1) define heart sounds, (2) obtain a quantitative timing of cardiac events, (3) accurately assess the nature and origin of a heart murmur from its response to various vasoactive maneuvers, and (4) record heart sounds, clicks, and murmurs when there is a question as to their presence, absence, or variations.

The phonocardiogram is a valuable diagnostic tool. We all vary in our ability to hear and time cardiac events. In many patients, the use of phonocardiography helps us more accurately ascertain what really is happening in the heart. In addition, it helps us improve our ability to auscultate and evaluate the various heart sounds and murmurs. There is no question that the astute, careful clinician can hear more than the phonocardiogram can record. However, even those physicians who spend a great deal of time improving and refining their skills in auscultation occasionally question the presence and timing of heart sounds. For those in whom this is not a full time endeavor, the phonocardiogram provides a simple, relatively inexpensive tool to assess and improve their skills.

Examples of cardiac events whose evaluation can be assisted by the phonocardiogram are:

I. Mitral Valve Disease
 A. Mitral Valve Prolapse
 1. Separate ejection from non-ejection clicks.
 2. Evaluate patients with questionable or multiple clicks and a technically poor or unobtainable echogram, or those who have a negative echogram but where a strong suspicion of prolapse is present.
 B. Ruptured Chordae.
 Tendinae with acute mitral regurgitation vs. chronic mitral regurgitation or mitral valve prolapse.
 1. Patients with ruptured chordae tendinae often have a murmur with characteristic crescendo-descrendo pattern which can be distinguished from that of chronic mitral regurgitation or mitral regurgitation associated with mitral prolapse alone.
 C. Mitral Stenosis
 1. The timing of the opening snap in mitral stenosis is sometimes associated with the severity of the disease.

* Dr. Silverman is Director of Cardiology, Northside Hospital, 1000 Johnson Ferry Rd., NE, Atlanta, GA 30342. Articles for this page are sponsored and approved by the American Heart Association, Georgia Affiliate. Those wishing to contribute papers to this page are invited to send them to Dr. Miltiadis Stefadouros, "Heart Page" Editor, Section of Cardiology, Dept. of Medicine, MCG, Augusta, GA 30912.

II. Aortic Valve Disease
 A. Congenital Aortic Stenosis
 1. The presence of a click followed by a murmur in early systole is usually, though not invariably, associated with congenitally stenotic or bicuspid aortic valve.
 B. Calcific Aortic Stenosis
 1. The intensity and duration of the aortic murmur has a rough correlation with its severity. In addition, a delay in the rate of upstroke and the duration of ejection time on the carotid pulse has a close association with a decrease in the aortic valve area, and is helpful in assessing aortic valvular stenosis.
 C. Hypertrophic Obstructive Cardiomyopathy (HOCM)
 1. Evaluates the change in murmur with position and other maneuvers and provides a record of typical carotid pulse contour.
III. Pulmonic Valve Disease
 A. The click of pulmonic stenosis is characteristic in that it represents the only right-sided sound that decreases on inspiration and is helpful in diagnosing this condition.
IV. Tricuspid Valve Disease
 A. The relationship of the loudness of the murmur to the phases of respiration is often helpful in diagnosing tricuspid disease and separating it from mitral disease.
V. Gallops, Clicks, and Extracardiac Sounds
 A. The presence of gallops or clicks is often important in the diagnosis of heart disease. Their timing and relationship to respiration are helpful in assessing the severity and extent of problems. An example is a split S1 vs. a normal S1 associated with either a click or an S4 gallop; or an S3 gallop vs. an opening snap or widely split second heart sound.

The phonocardiogram does not replace bedside auscultation, and, in fact, is not superior to careful astute examination. On the other hand, it can be very helpful for those of us who have not quite developed the skills of an Osler, Harvey, or Hurst.



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported; most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101

FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

Copyright © 1980, Wyeth Laboratories
All rights reserved.

Wyeth Laboratories
Philadelphia, Pa 19101

How Often Should a Pap Test Be Done?

JOHN L. POWELL, M.D., *Atlanta**

CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN) is becoming a major health problem, with some 45,000 new cases of carcinoma in-situ (CIS) estimated annually.[1] A conservative estimate of at least twice that many patients with dysplasia annually makes CIN the most common neoplasm affecting women.

It is accepted that cytologic screening is a mandatory part of any preventive medical program, and that women should be screened regularly at whatever age they begin sexual activity. The reason for this proviso is that the occurrence of squamous cell cancer of the cervix and its precursors is confined almost exclusively to women who have had sexual intercourse, and a higher relative risk is associated with early sexual experience and promiscuity. Although the peak group in the age-specific prevalence of CIS is in the 30-40 year range, the peak incidence rates occur in 20 to 30-year-old women. The earlier precursors, frequently termed dysplasia, may be seen in teenagers.

The author reviews various studies of the Pap test conducted in different countries and questions the American Cancer Society's decision to extend the interval between Pap smears for sexually active women.

Papanicolaou made his first observations in 1928, but the definitive monograph was not published until 1943 with the clinical support of Marchette and Traut.[2] The perfection and widespread use of the "Pap" smear after World War II led to a decline in the mortality from invasive cervical cancer to a point lower than ever before in the history of medicine. With the use of the Pap test, cervical cancer is now discovered at a much earlier stage. Traditionally, the view has been that because clinical signs or symptoms are absent in the intraepithelial stage, routine screening techniques are required to detect early lesions. Of all those tried, the Pap test is the most easily applied, economical, and effective.

The Pap test is not a diagnostic tool, however, and histopathologic confirmation must be obtained for diagnosis. Nevertheless, this does not negate its use as an accurate indicator of the severity of the lesion present. A well-taken single smear which is fixed properly and reviewed by a reputable cytopathologist has a minimal inherent false-negative rate of 15% to 20%.[3, 4, 5] Too frequently, clinicians rely completely on the report of a single cytologic smear examination as evidence of the absence of genital cancer, even though the patient may continue to have symptoms.

* Dr. Powell practices gynecologic oncology. Address reprint requests to him at The Foundation for Gynecologic Oncology, 5669 Peachtree Dunwoody Rd., NE, Atlanta, GA 30342. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

A report in 1968 by Singleton, Grant, and Rutledge[5] revealed a 21.1% false-negative rate for the initial Pap smear where cervical biopsy revealed CIS. In addition, 19.7% of the 518 cases with negative Pap reports later proved to have Stage I carcinoma by cervical biopsy. **A recent review[6] of the last 124 patients with cervical malignancy referred to our group revealed that 21 (17%) had had a negative Pap report in the last year before diagnosis and that 30 (24.2%) had had a negative Pap report in the last 2 years before diagnosis.** Virtually every gynecologist has found invasive disease in a woman with a recent negative Pap test. This points up the fallibility of the test and the need for frequent examinations.

The false-negative rate, however, cannot be directed only to the cytology laboratory. The accuracy of cancer screening must be a shared responsibility between the clinician and the cytopathologist. An inadequate cell sample is the most common cause of incorrect cytologic diagnosis; and, in general, the Pap study is no better than the clinician who takes the smear. **It is impossible for the cytopathologist to give an accurate interpretation unless the smear includes a complete circumferential scrape of the squamo-columnar junction as well as a sample from the endocervical canal.** The latter can be obtained by using either an external os aspirator, which we prefer, or a cotton-tipped applicator stick, either moistened or dry.

Although reducing the frequency of the Pap test has been recommended for "cost effective" reasons, the opportunity of the examination allows the physician to check for other more fatal malignancies, such as those of the breast, ovaries, or endometrium.

In addition, the utilization of a vaginal pool sample as the only source of cells is unacceptable because of its high false-negative rate.[7] Unfortunately, the reported false-negative rates are usually from better clinics and laboratories; those who have poor false-negative rates do not report them.

Self-obtained Pap smears, either by irrigation or scraping, are not recommended. They have a higher false-negative rate than those obtained by medical personnel[8] and do not offer the advantage of other screening tests.

How frequently a Pap smear should be taken has been debated for many years.[9] The annual Pap smear suggested by the American College of Obstetricians and Gynecologists and promoted by the American Cancer Society for decades still seems reasonable, probably mainly because of factors unrelated to CIN. The Pap smear is a tangible, well-established, and well-publicized cancer screening technique and is used to induce women to seek annual examinations. This enables the physician to screen for other malignancies more fatal than CIN, e.g., in the breast, colon, ovary, endometrium, and for other diseases such as hypertension and obesity. Therefore, the small proportion of the examination fee going toward the cytology smear seems warranted. As women and physicians become better educated in preventive health care, the actual smear itself may be selectively eliminated from the annual examination in certain low-risk women. Those women at high risk for CIN, i.e., young, sexually active women, may need smears taken more than once a year. The diagnosis of cervical cancer in women who have signs and symptoms, and the follow-up of women who have had an abnormal Pap test previously should be decided on an individual basis.

Recently the appropriate frequency of cytologic screening has been questioned based on a "cost effectiveness" ratio or "cost-benefit" ratio, as well as on inferences about the natural history of CIS or dysplasia.

The duration of time that CIS exists in a stage detectable by a Pap test prior to causing symptoms or progressing to invasive disease is a very important determinant of the "optimal" frequency for screenings. In the Walton Report,[10] a Canadian task force estimated from the peak ages of onset of CIN and invasive cervical cancer that the CIS lasts **up to 3 decades.** This method of

estimating the duration of a disorder is fraught with complications and biases, but the data do suggest a rather long interval. Several **other investigators** have used different statistical techniques, and the consensus appears to be that Pap-detected CIS lasts, on the average, **5 to 15 years** before progressing. A recent analysis by **Richart and Barron[11] estimated** the mean duration of CIS to be 10 years, with a lower limit for the CIS transit time of **approximately 3 years.**

Finally, it is commonly stated that the long-term survival of patients with CIS is virtually 100%. Furthermore, some cases of dysplasia and CIS may regress spontaneously. On the other hand, data on "regression" is difficult to interpret, since the biopsy used to diagnose and follow CIS may actually remove it, and any disappearance could be due to this "treatment" rather than to regression.

The Canadian program calls for a Pap test every 3 years in sexually active women between the ages of 18 and 35, and every 5 years in those from 35 to 60. Screening is done every 5 years in Great Britain. In Finland, every woman receives a personal invitation to be tested every 5 years. The American College of Preventive Medicine recommends having the test every 5 years.

The findings in the above mentioned studies provided the rationale for the recent major change in the recommendations of the American Cancer Society (ACS) regarding the "optimal" time interval between Pap smears.[12] The ACS currently recommends that all asymptomatic women age 20 and over, and those under 20 who are sexually active, have a Pap test annually for two negative examinations and then at least every three years until the age of 65. They claim that the upper age limit is justified by the extremely low number of cases detected in women over 65 who have been screened previously.

This author has personally cared for eight women over the age of 65 in the last year with primary invasive cervical cancer. They ranged in age from 68 to 88. Therefore, it is difficult for me to accept any age limitation.

The findings of the screening programs in countries with socialized medicine are impartial, dispassionate, objective, and coldly intellectual. My counterarguments are partly emotional and based on my experience. Emotion counts a great deal in human life and medical practice, and experience as well as intuition tell me that 3, 4, or 5 years is too long an interval between Pap smears. Orpheus lost his Eurydice because he ignored a warning not to gaze upon her until he was well out of Hades. I agree with the warning of Hugh Barber[13] that we should not gaze too often on the 3 and 5-year recommendation for Pap smear examinations until we have achieved the goal of wiping out invasive cancer of the cervix. It can be achieved in our lifetime. In the meantime, an estimated 74,000 American women will die from invasive cervical carcinoma in 1980.[14]

(EDITOR'S NOTE: On July 23-25, 1980, the National Institutes of Health sponsored a conference entitled, "Cervical Cancer Screening: The Pap Smear." The members of the panel made the following recommendations for screening asymptomatic women: (1) Virgins need not be screened for cervical cancer (there are some notable exceptions, such as those exposed to DES in utero); (2) all women who have had sexual intercourse should be screened; (3) screening should be initiated soon after the beginning of sexual activity. If the first Pap smear is negative and does not indicate evidence suggestive of neoplasia, the smear should be repeated in 1 year. If the second smear is also negative, rescreening of a majority of healthy women should be repeated at regular intervals of 1-3 years. ***The decision as to precisely how often a woman should have a Pap test should be made jointly by the woman and her physician. The panel did not agree on precisely how frequently these examinations should be repeated for healthy women of different ages.***

The opinions on this subject are as varied as the facts. Obviously more studies need to be undertaken to monitor the impact of changes in the Pap smear screening interval on the incidence in mortality rates of cervical carcinoma. The subject is highly controversial, but as Dr. Powell points out in his article, it is the health and

safety of each patient that is of paramount importance, and the decision regarding frequency of the Pap test should be made with each patient.

A complete copy of the report from the National Institutes of Health cited above may be obtained on request from the JOURNAL *office.)*

References

1. Silverberg E. Cancer statistics. CA 1979;29:6.
2. Papanicolaou GN, Traut HF. Diagnosis of uterine cancer by the vaginal smear. New York, Commonwealth Fund, 1943.
3. Richart RM. Evaluation of the true false-negative rate in cytology. Am J Obstet Gynecol 1964;89:723.
4. Jafari K. False-negative pap smear in uterine malignancy. Gynecol Oncol 1978;6:76.
5. Singleton WP, Grant D, Rutledge F. To cone or not to cone. Obstet Gynecol 1968;31:430.
6. Hershey DW, Burrell MO, Powell JL, Franklin EW. Unpublished data.
7. Richart RM, Vaillant HW. Influence of cell collection techniques upon cytological diagnosis. CA 1965;18:1474.
8. Arata T, Sekiba K, Kato K. Appraisal of self-collected cervical specimens in cytologic screening of uterine cancer. Acta Cytol 1978;22:150.
9. Marx JL. The annual pap smear: an ideal whose time has gone? Science 1979;205:177.
10. Canadian Task Force. Cervical cancer screening programs. Can Med Assoc J 1976;114:1003.
11. Richart RM, Barron BA. Screening strategies for cervical cancer and cervical intraepithelial neoplasia. Presented at the American Cancer Society National Conference on Cancer Prevention and Detection, Chicago, IL, April 17-19, 1980.
12. Guidelines for the cancer-related checkup. Recommendations and rationale. CA 1980;30:215.
13. Barber HRK. How often should a pap test be done? Female Patient 1980;5:13.
14. Silverberg E. Cancer statistics, 1980. CA 1980;30:31.



FROM DIETARY COMPLAINTS



"Too Bland"



"Tasteless"



"No Variety"



"Hard To Cook"

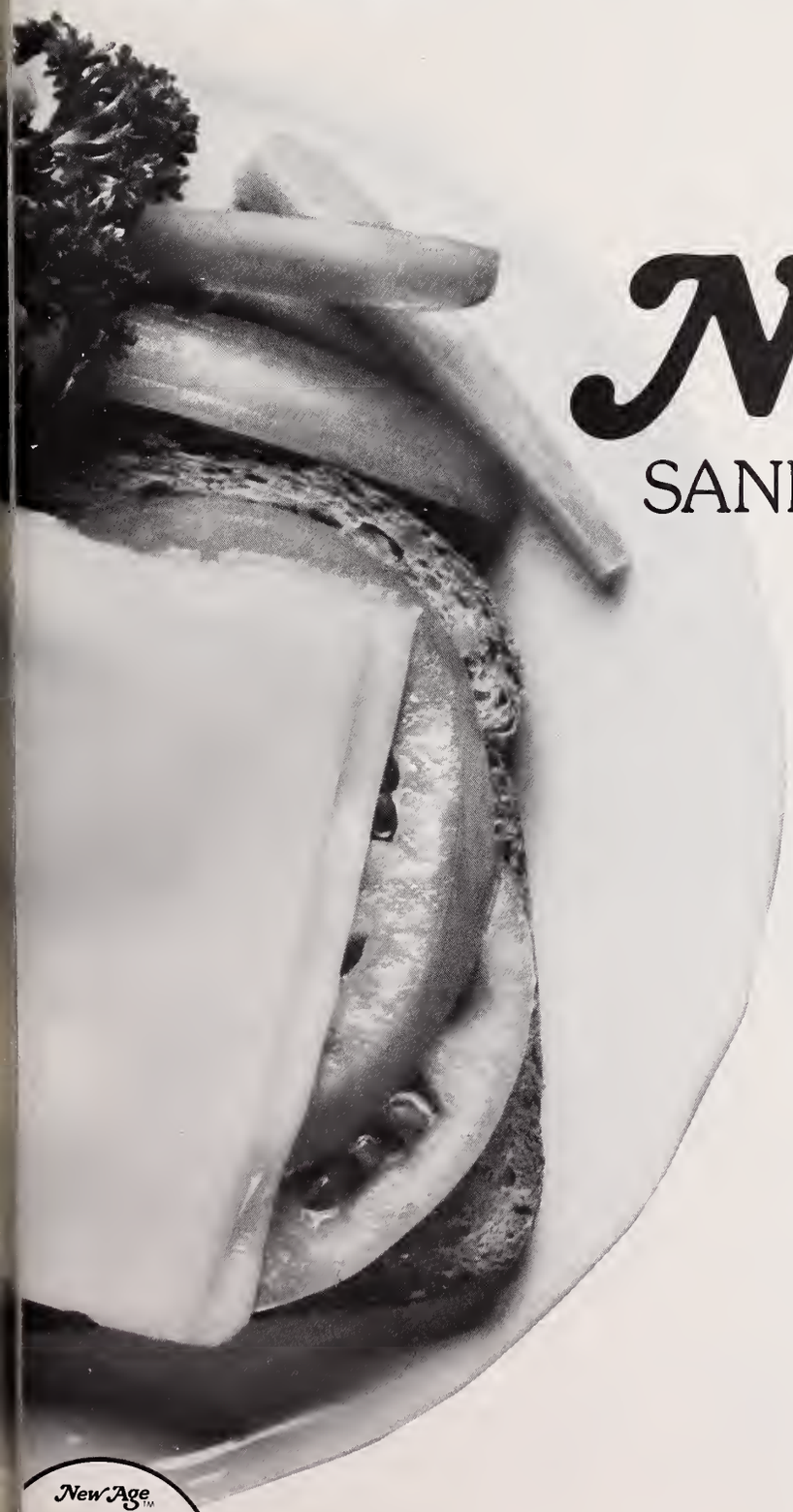


"Only Cottage Cheese?"



"Daddy's Dull Diet"

TO COMPLIANCE



INTRODUCING

New Age™

SANDWICH SLICES

- **90% less cholesterol**
- **75% less saturated fat**

Now, New Age—a cheese substitute made with vegetable oil—provides the good taste of process cheese without its restrictively high cholesterol content.

New Age has 90% less cholesterol, 75% less saturated fat, yet provides all the protein, vitamins and minerals of process cheese... good news for all health-conscious patients!

AMERICAN
SWISS
SMOKEY
HOT PEPPER



New Age™ is consistent with the cholesterol-control, low-fat recommendations of the third edition of **The American Heart Association Cookbook.**

©0 Anderson, Clayton & Co. Complete nutritional information is available from Anderson Clayton Foods, P.O. Box 226165, Dallas, TX 75266.

The Great CHEROKEE TRADING COMPANY

DEALERS IN

RARE COINS

- GOLD AND SILVER COINS
- INVESTMENT PROGRAMS
- KEOGH PLANS, IRA
- PROFIT AND PENSION PLANS
- APPRAISALS
- COLLECTIONS WANTED

INVEST IN COINS

RARE DAHLONEGA GOLD

THE GREAT CHEROKEE
3076 ROSWELL ROAD, NW
ATLANTA, GA 30305

PH. (404) 231-2210

Great Investment
With A Beautiful Return

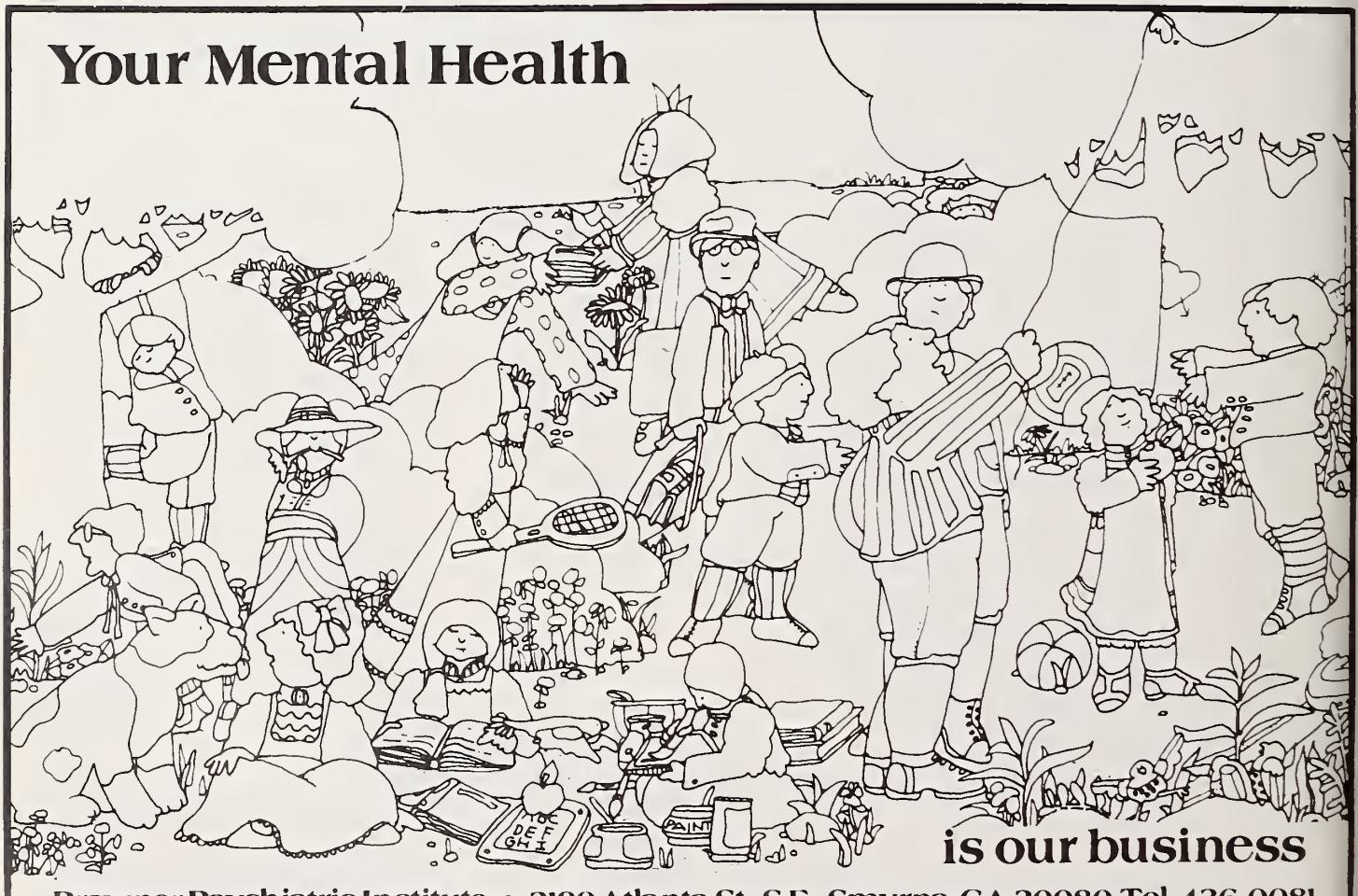
Oriental rugs from far and middle east have proven to be an excellent hedge against inflation; while adding beauty to your home or office.

House of Persia has been for 17 years, the source in Atlanta for fine oriental rugs. See our tremendous inventory of originals and start enjoying the security of an investment with a beautiful return.

house of persia

Next to Brennans in Buckhead
107 West Paces Ferry Road
Phone 266-8458
Hours Mon.-Sat. 9:30 A.M.-6:00 P.M.

Your Mental Health



is our business

Brawner Psychiatric Institute • 3180 Atlanta St., S.E., Smyrna, GA 30080 Tel. 436-0081

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.


COUGH
COUGH
COUGH

For Sneezing and Nasal Congestion



RU-TUSS® TABLETS

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

- Vasoconstrictor, antihistaminic actions
- Rapid and prolonged relief of nasal and sinus congestion
- Convenient b.i.d. dosage

Boots Pharmaceuticals, Inc.
Pioneers in Medicine

For Coughing With Nasal and Bronchial Congestion



RU-TUSS® EXPECTORANT

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

- Vasoconstrictor, antihistaminic, expectorant actions with codeine
- Rapid relief of upper respiratory congestion and cough
- Good tasting

reveport, Louisiana 71106.

r the Family

SNEEZE

RU-TUSS® TABLETS

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral-antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings:).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole

HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
Bottles of 500 Tablets	NDC 0524-0058-05

Federal law prohibits dispensing without prescription.

COUGH

RU-TUSS® EXPECTORANT

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 mg
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever allergies, nasal congestion and cough due to the common cold

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease Caution should also be used in patients with pulmonary, hepatic or renal insufficiency

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia Overdoses may cause restlessness, excitation, delirium, tremors, euphoria metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoontuls, orally, every 4 hours, not to exceed 10 teaspoontuls in any 24-hour period

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoontuls in ony 24-hour period Children 2 to 6 years of age: ½ teaspoontul every 4 hours, not to exceed 3 teaspoontuls in any 24-hour period Children under 2 years of age: Use as directed by a physician.

HOW SUPPLIED

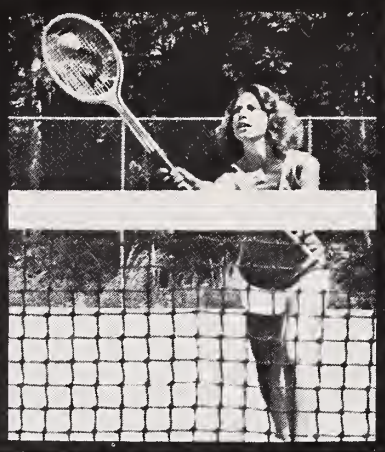
Pint bottles (16 fl. oz.)	NDC 0524-1010-16

Federal law prohibits dispensing without prescription.

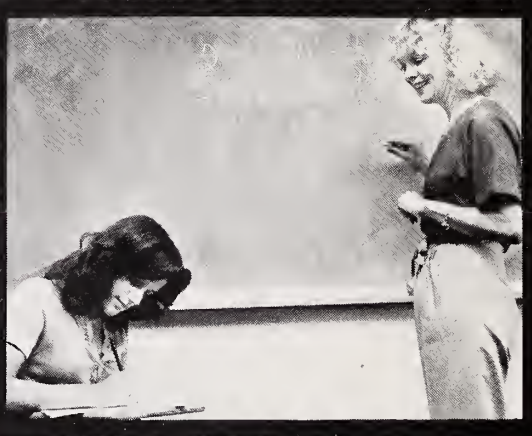
DISTRIBUTED BY:
Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

MANUFACTURED BY:
Vitarine Company, Inc.
Springfield Gardens, New York 11413

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106
Pioneers in Medicine For the Family






Ridgeview Institute

Ridgeview Institute is a private, non-profit, fully accredited psychiatric hospital located less than 20 minutes from downtown Atlanta. Ridgeview offers three individual, fully-accredited, separately-housed programs in alcohol and drug treatment, adult, and adolescent psychiatry.

A full range of treatment methods are available and a high staff-patient ratio assures individualized attention. Bright, warm colors and sunny interiors provide a non-institutional atmosphere as patients participate in a wide range of theraupetic and recreational activities.

Alcohol & Drug Program

This program offers a multi-dimensional treatment and rehabilitation program aimed at helping those afflicted with the disease of alcoholism or drug addiction. A variety of groups and activities are led by trained, experienced addiction counselors and therapists. Alcoholics Anonymous and Narcotics Anonymous are intrical parts of the program.

Adult Psychiatric Program

Under the psychiatrist's leadership, patients on the adult unit are treated individually for depression, anxiety, schizophrenia, manic depressive illnesses, personality disorders and other similar disfunctions. The physician and treatment team work closely together on the patient's assets as well as problems in the social, psychological and physical areas.

Adolescent Program

This unique program offers a wide range of treatment modes and emphasis is placed on resolving the emotional, behavorial and educational difficulties involving this age group. A fully accredited school lets the young people continue their education during the inpatient process. Classes are small and credits earned at Ridgeview are transferred back to their schools.

Ridgeview INSTITUTE

3995 South Cobb Drive

Smyrna, Georgia / (404) 434-4567

president's letter



A Champion — Attitude and Desire

The goals and priorities of the Medical Association of Georgia are clearly documented. We must have them to build upon; to move onward and upward. Otherwise we fail. With positive goals, MAG power is released, and things begin to happen.

Incentive is the soul of success. Success then becomes a journey and not a destination.

Ability to reach our goals is important. Dependability is critical, and we must not confuse activity with accomplishment. Our knowledge has to be constantly challenged, improved, and increased, or else it stagnates.

Nevertheless, the truly viable structure of our organization can be altered by our attitudes. Attitude has a multitude of facets; a posture or a position with a purpose. A positive, enthusiastic attitude is contagious and brings successful results.

The difference between an average performer and a champion is primarily desire. Let us resolve to totally perform in 1981 with positive attitudes, maintained and charged with motivation and enthusiastic desire.

H. Hilt Hammett Jr., M.D.

H. Hilt Hammett, Jr, M.D.
President, M.A.G.

NEW MEMBERS

Ackerman, Larry L., Ga. Med. Soc. — ACT — P
515 E. 63rd St., Savannah 31405

Alexander, William S., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Anderson, William J., DeKalb — N-2 — FP
231 E. Ponce de Leon Ave., Decatur 30030

Barlin, Rose L., Decatur-Seminole — ACT — PD
1502 E. Evans St., Bainbridge 31717

Carruth, Joseph E., Laurens — N-2 — CD/IM
606 Academy, Dublin 31021

Cibik, George M., MAA — N-2 — IM/GE
3250 Howell Mill Rd., NW, Ste. 305, Atlanta 30327

Curry, Sidney S., MAA — N-2 — D
3320 Holcomb Bridge Rd., Ste. 114, Norcross 30092

Eubanks, A. Benjamin, MAA — ACT — P
1935 Cliff Valley Way, Ste. 215, Atlanta 30329

Freeman, Donald L., St. John's Parish — N-2 — FP
303 Fraser Dr., Hinesville 31313

Hillson, Willie J., Richmond — N-2 — IM
Medical College of Georgia, Augusta 30912

Huff, Garey H., Barrow — N-2 — FP
206 Candler St., Winder 30680

Jackson, Eugene H., Muscogee — I&R
The Medical Center, Columbus 31994

Jann, William K., Jr., DeKalb — N-2 — PD
1901 Century Blvd., Ste. 20, Atlanta 30345

Knapp, William S., MAA — N-2 — CD/IM
3250 Howell Mill Rd., Ste. 306, Atlanta 30327

Lois, Thomas A., Gwinnett-Forsyth — N-2 — PS
2121 Fountain Dr., Ste. K, Snellville 30278

Maddox, John F., Muscogee — I&R
The Medical Center, Columbus 31994

McKain, Thomas W., Muscogee — I&R — FP
The Medical Center, Columbus 31994

McMahan, Howard C., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Miller, James P., Muscogee — I&R
1005 Talbotton Rd., Columbus 31995

Mobley, Michael C., Richmond — N-1 — P
MCG, Psychiatry Dept., Augusta 30912

Nijem, William C., South Georgia — N-2 — CD/IM
1700 N. Patterson St., Valdosta 31601

Otts, John C., Laurens — N-2 — FP
Erin Office Park, Dublin 31021

Paris, Ray B., Muscogee — I&R — FP
P. O. Box 951, Columbus 31994

Peeler, Ralph D., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Pennington, James W., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Pratt, Edwin V., Muscogee — I&R
P. O. Box 951, Columbus 31902

Roberts, Reuben S., Jr., Ocmulgee — N-2 — FP
Pulaski Professional Bldg., Hawkinsville 31036

Rychly, Robert E., Richmond — N-2 — IM
820 St. Sebastian Way, Ste. 7-A, Augusta 30901

Schwin, Robert L., MAA — N-2 — P
256 Boulevard, NE, Atlanta 30312

Sedlak, Justin B., Muscogee — I&R
710 Center St., Columbus 31900

Smith, William C., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Sperk-Bard, Eva, Stephens-Rabun — N-2 — PTH
Stephens County Hospital, Toccoa 30577

Stewart, Richard C., St. John's Parish — N-2 — FP
303 Fraser Dr., Hinesville 31313

Thomas, Dawn A., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Thomas, Dennis R., Muscogee — I&R — FP
The Medical Center, Columbus 31994

Tuck, James M., Jr., Muscogee — I&R — FP
P. O. Box 951, Columbus 31902

Varma, Jaydev, Richmond — ACT — FP
MCG, Family Practice Center, Augusta 30912

Young, Henry W., Muscogee — I&R — FP
The Medical Center, Columbus 31994

PERSONALS

Second District

Tifton ophthalmologist, **Larry Moorman, M.D.,** has been elected chief of staff at Tift General Hospital. Other MAG members elected to staff positions at that hospital include **Jesse D. Hester, M.D.** (vice president) and **Gerald L. Sapp, M.D.** (secretary).

Third District

Jack Lawler, M.D., formerly of Carrollton, has been appointed to The Medical Center Hospital Authority Board of Trustees in Columbus by the Columbus City Council.

Fourth District

G. Douglas Talbott, M.D., of Smyrna, was the guest speaker at Georgia Baptist Medical Center's quarterly medical staff meeting in October. Dr. Talbott spoke on the Medical Association of Georgia's Disabled Doctors Program.

Fifth District

Amir Ansar, M.D., Atlanta, recently presented a paper entitled, "Diagnosis and Management of IUD with Missing Tail," at an international symposium in Bordeaux, France. At the 10th World Congress on Fertility and Sterility in Madrid, Spain, Dr. Ansar was one of three faculty members of a pre-congress course on "Clinical Reproductive Endocrinology." He also served as a panel member in a special symposium on "Tubal Microsurgery."

Wallace C. Campbell, M.D., of Atlanta, has received a grant-in-aid from the American Heart Association, Georgia Affiliate. Dr. Campbell is conducting a project aimed at reducing early death and disability from heart disease.

Edwin C. Evans, M.D., and **William D. Logan, Jr., M.D.,** of Atlanta, were featured speakers at the National Association Medical Staff Services' fourth annual convention recently held in Atlanta.

Northside Hospital has announced its medical staff officers for the 1980-81 year. MAG members elected are **Thomas W. Gable, M.D.,** chief of staff, and **Milton S. Goldman, M.D.,** vice chief of staff.

Hamilton E. Holmes, M.D., Atlanta, was recently appointed to the Georgia Baptist Medical Center staff.

William E. Huger, Jr., M.D., of Atlanta, was re-elected as treasurer of the American Society of Plastic and Reconstructive Surgeons. Dr. Huger, who practices plastic and reconstructive surgery, was installed at the society's 49th annual meeting in New Orleans.

Paul E. Stanton, Jr., M.D., presented a program on "Carotid Artery Kinks" at the National Naval Medical Center and Uniform Services University in Bethesda, Maryland.

Sixth District

David P. Fieseler, M.D., has opened a practice in Thomaston.

On October 1, **Patrice Sapp, M.D.,** opened a family practice in Gray.

The 20th annual meeting of the Troup County Unit of the American Cancer Society was dedicated to **Hoke Wammock, M.D.,** LaGrange, upon his retirement as director of the Enoch Callaway Cancer Clinic. At the same meeting, **M. Julian Duttera, Jr., M.D.,** LaGrange, was elected medical vice president of the Unit for 1980-81.

Seventh District

Ronald C. Bloodworth, M.D., was recently appointed to the Georgia Baptist Medical Center medical staff. He was also named Clinical Director of the Psychiatric Institute of Atlanta as of October 1.

Virginia D. Hamilton, M.D., District Director of Health, Georgia Department of Human Resources, District I, Unit I, was speaker at the October meeting of Paulding Charter Chapter of the American Business Women's Association.

Former Fairmount pharmacist, **Dewey Hammond, M.D.,** is now the city's new physician. Dr. Hammond officially began practicing at the Fairmount Primary Health Care Center on October 20.

Joe L. Griffeth, M.D., Commerce, was elected secretary of the Georgia District of Kiwanis International.

Gerald Stapleton, M.D., Austell, was recently elected president of the Greater Atlanta Otolaryngology Society.

SOCIETIES

"HMOs — Their Impact on the Private Practice of Medicine" was the topic of the **Cobb County Medical Society's** November meeting. MAG members who participated on the panel for the program included **Nicholas M. Bath, M.D.,** Decatur; **William R. Hardcastle, M.D.,** Decatur; **O. Wytch Stubbs, Jr., M.D.,** Tucker; and **Charles W. McDowell, Jr., M.D.,** Decatur.

At the September meeting of the **Muscogee County Medical Society (MCMS), Charles D. Hollis, M.D.,** of Albany, spoke on "Should MAG Self-Insure?" On October 9, the MCMS held a barbecue at the Green Island Country Club for the new members of the Society. Special guests included Dr. and Mrs. Newton Turk, of Atlanta. Dr. Turk is MAG's President-Elect. Ms. Miriam McLendon, Ms. Dottie Dance, Mr. Bert Franco, and Mr. Steve Davis of the MAG staff also attended.

Dr. Timothy Ryles, Administrator of Consumer Affairs for Georgia, spoke to the Annual Ladies Night of the **MCMS,** on October 18 at the Harmony Club. Dr. Ryles' topic was "What Does the Public Think of Medicine?"

DEATHS

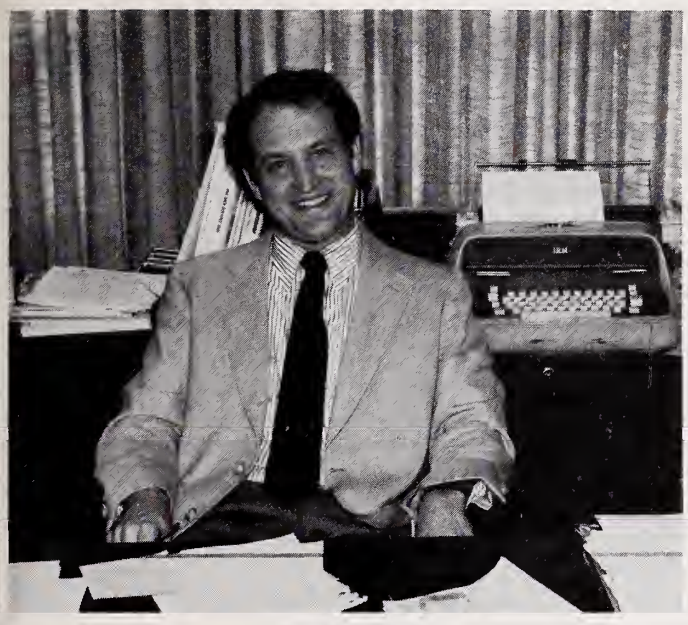
Robert E. Talley

Robert Ellis Talley, a general surgeon and a native of Columbus, died Thursday, October 16. He was 52.

Dr. Talley was a member of the Muscogee County Medical Society, the Medical Association of Georgia, the Southern Medical Association, the American Osteopathic Association, the American Medical Association, and was a Diplomate of the American College of Surgeons. He was a member of the Waldrop Memorial Baptist Church.

Survivors include his wife, three daughters, three sons, a brother, two half-sisters, and a half-brother. In lieu of flowers, the family requests that contributions be made to a favorite charity.

Two New Members Join MAG Staff



Stephen Davis



Gary W. Price

In September, Stephen Davis assumed the position of Director of Education for the MAG, replacing Stephen Daniel. Steve earned his doctorate from Emory University's Institute for the Liberal Arts, where he specialized in Southern history and literature. He comes to this position with 6 years' experience as an educator at both secondary and college levels. Prior to his joining the MAG, he served as Assistant to the Director, Institute of the Liberal Arts. There his responsibilities included staffing faculty meetings, coordinating financial aid, and interviewing student applicants.

Steve is married and has lived most of his life in Atlanta. He continues his interest in history by occasionally preparing an article for such publications as *Civil War History, Mississippi Quarterly,* and *Georgia Historical Quarterly.*

Gary W. Price joined the MAG staff on October 15, as Assistant Director of Legislative Activities. In addition to his legislative duties, Mr. Price will also assist in MAG's Public Relations activities.

Mr. Price, a native of the Atlanta area, received a Bachelor's degree in Political Science from West Georgia College. He comes to the MAG from the Georgia State Senate where he served as Director of Research. The experience Mr. Price gained during his three and a half year tenure with the State Senate adds considerable depth to MAG's legislative activities.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award for September, 1980.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We contratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Walter Faust Anderson, Dunwoody
William Stanley Arnold, Atlanta
Garry Lewis August, Columbus
Jackson Howell Bates, Marietta
Antonio Vicente Baute, Augusta
Marcia Bender Guzzardo, Warner Robins
Richard Warren Eells, Decatur
Frederick E. Gilbert, Newnan
Hshi Yung Hu, Comer
John Butler Hunt, Valdosta
Norman Frederick Jacobs, Decatur
Horace A. W. Killam, Augusta
Tae Won Kim, Albany
George Collier King, Clayton
Alan David Kirsh, Macon
Robert McClure, Lilburn
George Matthews McCord, Atlanta
Ngoc Minh Pham, Rome
Edward Vann Roberts, LaGrange
Reginald Dillard Smith, Decatur
Lillian Pearl Warnick, Atlanta
Charles L. Whisnant, Atlanta
Nilda Beatriz Winiarski, Atlanta
Robert K. Worman, Columbus

Auxiliary to MAG Sponsors Two Health Workshops



DR. PEARLINE YEATTS (Mrs. Charles B. Thomas), A-MAG member and psychology faculty member at the University of Georgia, spoke on drug abuse and offered workshop attendees insight and instruction in its prevention. She stressed how poor parenting was a significant factor in drug abuse among children.

In keeping with the AMA Auxiliary's ongoing national theme, "Shape Up For Life," and its aim to reach entire communities, the Auxiliary to MAG sponsored two "Total Health Workshops" in October, 1980.

On October 14, an all-day seminar was held at the Rural Development Center in Tifton. There were 112 registrants, including auxiliary members from eight counties, school teachers from 11 counties and 21 schools in South Georgia, and local citizens.

The week beginning October 12 had been designated "Drug Awareness Week" in Tifton, and emphasis at the meeting was placed upon chemical substance abuse. Speakers were Mrs. Sue Rusche, director of DeKalb County's "Families in Action," and Dr. Pearline Yeatts, an auxiliary member who is on the psychology faculty at the University of Georgia. Other sessions were held on make-up, diet, and exercise.

A similar program was held on October 21 at Ridgeview Institute in Smyrna. Participants included Dr. Yeatts, who spoke on "Parent-Spouse and Parent-Child Communication to Prevent Drug Abuse"; Dr. J. T. Cooper, of Marietta, who discussed "Diet and Exercise"; members of the Ridgeview staff who talked about drug and alcohol addiction; and experts from an Atlanta department store who told the women about current fashions in make-up and hairstyling.

The workshops were spearheaded by Ann Satcher (Mrs. Milton B.), A-MAG President; Ann Smith (Mrs. Robley D.), Health Education Chairman; Pearline Yeatts Thomas (Mrs. Charles B.), Mental Health Chairman; June Hudson (Mrs. Carlton B.), Health Education Co-chairman; and Jeanne Boger (Mrs. Robert M.), Mental Health Co-chairman.

(Reported by Ann Smith (Mrs. Robley D.) of Tifton and Evelyn Gay (Mrs. Brit B.), A-MAG Historian and Editor of Pulse Line.*)*

Physician Involvement Program (PIP)

The **Physician Involvement Program (PIP),** which will begin with the start of the 1981 General Assembly, is designed to give physicians an organized input into the legislative process.

Each day that the legislature is in session (January 12 to mid-March), 10 physicians will be in attendance at the Capitol. The day will begin with coffee in MAG's suite at the Stadium Hotel (located two blocks south of the Capitol on Capitol Avenue) at 8:30 a.m. At 9:00 a.m., there will be a briefing session which will include an explanation of how legislation is introduced, considered in committee, and voted on by each House. The briefing will also include a summary of legislation that MAG is tracking and an explanation of any bills that will be considered that day.

Prior to the legislature convening at 10:00 a.m., the physicians will go to the Capitol to meet their legislators. They will then be able to observe the legislative session and attend any committee meetings. Hopefully, many will have an opportunity to have lunch with various legislators and talk about mutual interests and goals.

To become involved in this program, call Carol Greene at MAG to schedule your day, or, if you have any questions, call Mr. Rusty Kidd. In Atlanta call 876-7535; long distance call toll free 1-800-282-0224.

Physicians Invited to Attend a Medical Historical Society Meeting

All physicians and other historical buffs are cordially invited to attend an organizational meeting of the Atlanta Medical Historical Society. This exciting event will occur at 8:00 P.M. on Wednesday evening, January 14, 1981, at the Atlanta Historical Society, 3099 Andrews Drive, NW. Future plans will be discussed, and Dr. James Harvey Young, Candler Professor of American Social History, Emory University, will discuss "American Health Quackery: A Historical View." Please attend and become a charter member of a new, important organization that will fill a void in your cultural life!

Mark Silverman, M.D.

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$10.00 for the first 25 words; $.25 per word for each additional word. **Non-members**—$20.00 for the first 25 words; $.25 per word for each additional word. *Charges are payable in advance*. Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact *Journal* staff at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535. INWATS in Georgia (800) 282-0224.

PHYSICIANS WANTED

Surgery Director. Opening for Director of Residency Training Program in Surgery with Pensacola Education Program, Pensacola, Florida, for Board-certified physician. Total program of 52 residents in six different residencies (7 residents in 5-year Surgical Program) associated with 4 different hospitals in community-based educational program. Salary competitive, with excellent fringe benefits of paid vacation, liability insurance, health and disability insurance, paid educational and professional trips. Program affiliation with several large medical schools. Gulf Coast living at its best and health care in immediate area of over ¼ million. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education, 904/477-4956, or send CV to Director of Medical Education, Pensacola Educational Program, 5149 N. Ninth Ave., Ste. 307, Pensacola, FL 32504.

Outstanding opportunity for a physician with an established clinic equipped and ready for you to start your practice. Practice opportunities unlimited. For more information, please call Mrs. Martha Powers, 926-4473, after 7:00 p.m. — 926-5841.

Central State Hospital, Milledgeville, has need for specialists in the fields of psychiatry, pediatrics, and surgery. Beginning salary up to $47,406 annually, depending on qualifications — subsequent annual increases of approximately 5%. Excellent fringe benefits. Qualifications: Graduation from a medical school recognized by the Composite State Board of Medical Examiners and training and supervised clinical experience sufficient to qualify as Board eligible for the appropriate medical specialty and licensure to practice medicine at a state institution or in the State of Georgia as provided by state law. For additional information, contact B. T. Atchison, Personnel Analyst, Central State Hospital, Milledgeville, GA 31062. Phone: (912) 453-4094. Applications will be accepted continuously until suitable applicants are located. Equal Opportunity Employer.

OB/GYN Board eligible or certified. Full time to do 1st and 2nd trimester pregnancy terminations on out-patient basis. Also routine GYN. Will provide specialized training if necessary. Must be willing to re-locate to southern city. Write Box 12-B, c/o the *Journal*.

SITUATIONS WANTED

Board certified, young internist is looking for association in a group or clinic, or purchase of an active practice. Atlanta vicinity preferred. Write Box 11-A, c/o the *Journal*.

Internist/Cardiologist. ABIM certified presently in practice wants to relocate. Available immediately. Write Box 12-A, c/o the *Journal*.

FOR SALE

Attention Medical and Dental Specialists — Office space is now available at very reasonable rates. WILLIAMSBURG MEDICAL CENTER seeks complimentary additions to a respected group of specialists. If you are considering establishing or moving your practice to a convenient location in DeKalb County, call (404) 634-1234.

Well-established general practice with fully equipped, large office available immediately to American-trained physician. Adjacent to 65-bed modern general hospital. Terms available on equipment. Please respond to Box 11-B, c/o the *Journal*.

For Sale. Various leather and vinyl chairs, 2 (Chippendale) Sofas — perfect for extra office. (404) 351-0351.

Remote Mountain A-Frame. Looking for the unusual yet ideal Christmas present for your loved ones? How about something guaranteed to bring your family closer together? A two-story, 3 BD, 1 bath, fully furnished, geared for year-round living, remote mountain A-frame on a rushing mountain stream. Beautiful, lush, forest setting with large deck overhanging 50 ft. wide stream. Ideal for fishing and rafting. Located in Fannin County, 10 miles from Blue Ridge Lake. Contact owner: K. M. Williams, 836 Ponce de Leon Terrace, NE, Atlanta. GA 30306, or call 873-4360 after 6 p.m. Price firm: $37,500.

HANDICAPPED PHYSICIANS

I am a multiply-handicapped doctor interested in contacting other handicapped physicians in order to obtain some approximation of the size and characteristics of this population in the United States and Canada. There is currently no organization to provide statistical data on the career patterns of such individuals or to what extent various handicaps affect the physician's ability to remain in active practice. Should any physician become handicapped, such information would be of utmost value in determining the feasibility of remaining in any chosen field and would also provide some indication of the career opportunities available to this unique population.

All physicians, active or inactive, with any type of physical handicap are asked to contact F. Zondlo, M.D., St. Paul-Ramsey Medical Education and Research Foundation, 640 Jackson St., St. Paul, MN 55101.

IRA, Keogh– enjoy today while you plan for tomorrow.

Fulton Federal's IRA is designed for you if you are self-employed or employed but not presently covered by a qualified retirement plan.

With IRA (Individual Retirement Account), you can plan for tomorrow by contributing as much as 15% of your compensation (or earned income if you are self-employed) not to surpass $1500 in any one year. IRA allows your savings plus interest to be compounded and tax deferred until retirement or age 59-1/2. Consequently, when you do begin withdrawing money, you will probably be in a lower tax bracket, thus your taxes will be less.

Keogh is designed for you if you are self-employed. With the Keogh retirement plan, your savings plus interest is also compounded and tax sheltered until time of withdrawal. You may deposit 15% of your earned income, not to exceed $7500 in one year.

For more information, call Fulton Federal's Retirement Plan Counselors at 586-7031. IRA and Keogh, two ways to plan for tomorrow.

Fulton Federal Savings

Fulton Federal Savings and Loan Association of Atlanta • P.O. Box 1077 • Atlanta, Georgia 30370

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

REG NO.

THE DEVEREUX FOUNDATION

ARIZONA
CALIFORNIA
CONNECTICUT
GEORGIA
PENNSYLVANIA
MASSACHUSETTS
TEXAS
ARKANSAS

M

DATE

Age Pre-Adolescents Adolescents & Young Adults

℞

HEDGES TREATMENT CENTER

Intensive psychiatric care for youths and young adults in transition, those who are not fully ready to utilize a conventional residential treatment approach but whose problems are not severe enough to warrant psychiatric hospital attention.

M.D.

℞

Age 17-24

CAREER HOUSE

For intellectually bright high school graduating seniors, and post-high school youth with problems of underachievement and/or personal adjustment. Psychotherapy, academic and vocational counseling. Arrangements made for enrollment in local colleges and career schools.

M.D.

Age Under 10

℞

CENTER FOR AUTISTIC AND SCHIZOPHRENIC CHILDREN

A comprehensive, short-term, residential treatment program for severely disturbed children under ten years of age.

M.D.

℞

Age Adolescents and Adults

EDWARD L. FRENCH REHABILITATION CENTER

C. A. R. F. Approved

Residential and day programs. Comprehensive vocational evaluation, training and placement services. Opportunities for social adjustment training, work adjustment training, and sheltered employment.

M.D.

. . . And many more separate day and residential treatment programs **prescriptively planned** for children and young adults with emotional and mental disabilities

Helena T. Devereux
Founder

Joseph B. Ferdinand
President

FOR INFORMATION AND LITERATURE:

National Director of Admissions is Charles J. Fowler, whose office is headquartered in Devon, Pa. 19333

PENNSYLVANIA Ellwood M. Smith, Admissions Director, Devon, Pa. 19333 or call 215 687-3000
CALIFORNIA Keith A. Seaton, Admissions Director, Box 1079 Santa Barbara 93102or call 805 968-2525
TEXAS Betty H. Templin, Admissions Director, Box 2666, Victoria 77901 or call 512 575-8271
ARIZONA Richard A. Etter, Director, 6436 E. Sweetwater, Scottsdale 85254 or call 602 948-5857
GEORGIA Ralph L. Comerford, Director, 1980 Stanley Road, N. W., Kennesaw 30144 or call 404 427-0147
CONNECTICUT Theodore E. Enoch, Director, Sabbaday Lane, Washington 06793 or call 203 868-7377
MASSACHUSETTS Frederic A. Hervey, Director, Miles Road, Rutland 01543 or call 617 886-4746

. . . Carrying the Promise of Happy Tomorrows



THE DEVEREUX FOUNDATION

A NONPROFIT ORGANIZATION

All Devereux Branches Surveyed by the Joint Commission on Accreditation of Hospitals are Approved as Psychiatric Facilities for Children and Adolescents

JOURNAL
of the medical association of
georgia

Index — Volume 69 — 1980

Month	Pages
January	1- 72
February	73-158
March	159-250
April	251-330
May	331-414
June	415-576
July	577-648
August	649-728
September	729-804
October	805-882
November	883-952
December	953-1024

Key to abbreviations appearing before page numbers:

C — Cancer Page
E — Editorial
H — Heart Page
L — Legal Page

AUTHOR INDEX

Author	Page
Adams, Hans W., M.D.	759
Alonso, Kenneth B., M.D., F.A.C.P.,	371, 917
Armstrong, William J.,	L-859, L-935
Atkins, Earnest C., M.D.	54, 144, 240, 320
Baker, J. Jay, M.D.,	E-919
Baisden, C.R., M.D.	699
Barrett, Timothy J.	971
Benson, Janie	118
Berg, Robert N.	L-34, L-127, L-229, L-387, L-621, L-711, L-785, L-987
Bernard, Jack	601
Birge, Jack E., M.D.	H-631
Black, Judson G., M.D.	E-849
Blake, Paul A., M.D.,	971
Boineau, John P., M.D.,	13
Brown, C. William, M.D.,	193
Bryant, Avalon Woodruff	273, 589
Bryant, John H., M.D.,	293
Burrell, Matthew O., M.D.	C-317
Cabaniss, C. Daniel, M.D.	H-131
Canedo, Mario I., M.D., F.A.C.C.	H-863
Center for Disease Control (CDC)	117, 749
Chandora, Deen Bandhu, M.D.,	769
Chapman, Stanley L., Ph.D.,	668
Clark, Letitia, M.D.,	359
Cowgill, Robert, M.D.	264, C-629
Cohen, Sheldon B., M.D.	E-721
Curry, Robert H., M.D.	837
Daniel, Stephen L., Ph.D.,	64
Davies, Nicholas E., M.D.	377
Davis, Dave M., M.D.,	385
Dee, Robert F.	E-615
Dennis, Anne B., CMA-A	167
Dickinson, John I., M.D.	196
Dillon, Susan J.	102
DuBois, Richard E., M.D.	E-37
Dunbar, Walter S., M.D.	E-984
Dykes, M.L., M.S.	965
Egan, Robert L., M.D.	E-125
Emmons, Julia	904
Fatteh, Mehboob, M.D.	765, 977
Feldman, Elaine B., M.D.	837
Fiedotin, Arnoldo, M.D.	H-723
Fisher, John F., M.D.	109
Forbes, Allan L., M.D.	845
Foster, G. R., Jr., M.D.	371
Gardner, Hoyt D., M.D.	663
Gay, Evelyn (Mrs. Brit B.)	
Hall, W. Dallas, M.D.	745
Hames, Curtis G., M.D.	H-395
Hammett, H. Hilt, Jr., M.D.	404, 566, 570, 634, 715, 788, 865, 941, 1008
Harbin, Bannester, Jr., M.D.	167
Harper, Thomas D.	L-313, L-785
Heymsfield, Steven B., M.D.	815
Higginbotham, Fred R.	367
Heyden, S., M.D.	H-395
Hollis, Charles D., Jr., M.D.	E-617
Horowitz, Jed, M.D.	815
Hunt, Sara M., Ph.D.	H-43
Jablonowski, Adam R., M.P.A.	895
Jackson, Dee, M.T., A.S.C.P.	597
Johnson, Martha Jane, M.S., R.N.	841
Kaufmann, James A., M.D.	9, 281
Kay, Bonnie J., Ph.D.	895
Kenny, William R., M.D.	205
Kidd, Rusty	9, 281
Kim, Tae H., M.D.	C-47
Krauss, J.S., M.D.	699
Lee, Jeffrey R., M.D.	755
Levy, Maurice, Ed.D.	837
Linder, Charles W., M.D.	217
Lokey, Julian L., M.D.	E-919
Lopez, Carlos E., M.D.	597
Lowance, David, M.D.	284
McCord, Clinton D., Jr., M.D., F.A.C.S.	27, 118
McDowell, Charles W., Jr., M.D.	244
McGinnis, LaMar S., M.D.	E-983
Mainz, David L., M.D.	759
Mallari, Raymundo T., M.S.	371
Matthews, Rev. Daniel P.	E-982
May, Donald F., R.R.T.	205
Merrill, Arthur J., Jr., M.D.	H-924
Miller, Max D., Ed.D.	217
Morton, William J., M.D.	901
Mossbrook, Sandra, M.D.	841
Otkin, L.B., M.D.	699
Ott, Larry L., C.P.A.	855
Payne, F. Edward, M.D.	E-780
Pellegrino, E.D., M.D.	174
Pendergrast, William J., M.D., F.A.C.S.	755
Pirozzi, Donald J., M.D.	345
Powell, John L., M.D.	C-399, C-995
Price, Norma A., M.D.	E-919
Ragab, Abdelsalam H., M.D.	C-47
Rankin, Jocelyn A.	965
Rao, Raghunatha, M.D.	109
Rao, V.R., M.D.	668
Reid, C.B., M.S.L.S.	965
Richardson, H. Dale, M.D.	193
Rodriguez, A.P., M.D.	C-137
Rodriguez, Antonio R., M.D.	355
Rogers, Harrison L., Jr., M.D.	E-307
Rosengart, Carl L., M.D.	E-719
Rubin, Joseph W., M.D.	13
Russell, Philip W., M.S.H.S.	895
Schoborg, Thomas W., M.D.	C-137
Scott, Charles, Jr., M.D.	C-137
Seklecki, Roger M., D.O.	217
Sendelbach, G. Andrew, B.S.	371
Settles, Sue A., B.S.H.S.	895
Silverman, Barry D., M.D.	H-991
Silverman, Mark E., M.D.	377
Smith, Ann (Mrs. Robley)	
Smith, Janet, M.M.Sc., R.D.	815
Someren, Ayten, M.D.	359

Stefadouros, Miltiadis A., M.D. H-777
Stenson, Robert, Jr., ... 13
Stewart, Richard B., M.D. 609
Still, Joseph M., Jr., M.D. 121
Strong, William B., M.D. 217
Sullivan, Louis W., M.D. 673
Sweet, Davie 971
Talledo, O.E., M.D. 699
Talton, I., M.D. H-395
Timm, Cynthia N., M.L.S. 377
Tippins, William C., Jr., M.D., F.A.C.O.G. 23
Tobian, Louis, M.D. 827
Tollison, C. David, Ph.D. 121
Tollison, Joseph W., M.D. 121
Underwood, Charles R., M.D. C-725, 869
Vohman, M. Darius, M.D. 755
Walker, George S., III, M.D. 704
Waller, Roy M., III, M.D. 359, 609
Watson, Donna R., M.S., R.D. 841
Webster, Paul D., III, M.D. 759
Wesley, Ralph E., M.D. 118
Williams, Kenneth M. 244
Wills, Charles E., Jr., M.D. 301
Wilson, Frank L., Jr., M.D. E-223
Winokur, Stanley H., M.D. E-919
Woodsides, Kenneth T., M.D. E-223
Woodward, J.J., M.D. 186
Woody, Edgar, Jr., M.D. E-306, E-379
Zakas, Dennis L. L-711

SUBJECT INDEX

— A —

ABORTIONS
On Medical Ethics (Payne) E-780
Recent Developments in the Health Care Areas (Harper, Berg) L-785
State-Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgment (Harper) L-313
ADDICTION
Delayed Diazepam Withdrawal Syndrome: A Case of Auditory and Visual Hallucinations and Seizures (Chandora) 769
ALCOHOLIC CIRRHOSIS
Association of Chronic Pancreatitis and Alcoholic Cirrhosis (Adams, Webster, Mainz) 759
AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS
The American Association of Medical Assistants, Georgia State Society (Harbin, Dennis) 167
Georgia Chapter of the American Association of Medical Assistants Holds Its Annual Meeting in Valdosta 658
AMERICAN CANCER SOCIETY
Quit Smoking Tips From the American Cancer Society 337
AMERICAN HEART ASSOCIATION, GEORGIA AFFILIATE
Georgia Heart Association Plans Nurse Conferences in Eight Georgia Cities 744
State Heart Association Names New Officers 658
AMERICAN MEDICAL ASSOCIATION
AMA Advises No Increase in NHSC Till More Studies Completed 888
Medicine: It's a Beautiful Story (Gardner) 663
ANTITRUST LAWS
Reconciling the Antitrust Laws and the Health Care Laws (Berg) L-127
APPROPRIATENESS REVIEW
Appropriateness Review: The Georgia Experience (Bernard) 601
AUXILIARY TO THE MAG
AMA Auxiliary Holds Annual Conference 810
Auxiliary Sponsors Workshop 888
Auxiliary to MAG Sponsors Two Health Education Workshops (Smith, Gay) 1012
A Beautiful Partnership (Hammett) 788
Communications Workshop for Auxiliary 656
55th Annual Auxiliary Convention, Greetings 100
1980 Auxiliary Annual Convention Schedule 101

— B —

BIOFEEDBACK
Biofeedback Therapy in Clinical Practice (Chapman, Rao) 668
BIRTHMARKS
Argon Laser Treatment for Superficial Vascular Lesions 743
BREAST
A General Surgeon Looks at Breast Reconstruction (Underwood) C-725
BRUCELLOSIS
Clinical Note: Brucellosis (Sendelbach, Alonso, Mallari, Foster) 371
BURN TREATMENT
The Seriously Burned Adult: Psychologic Reactions, Recovery, and Management (Tollison, Still, Tollison) 121

— C —

***CAMPYLOBACTER* ENTERITIS**
Campylobacter enteritis (Lopez, Jackson) 597
Isolation of *Campylobacter fetus* subspecies *jejuni* in Georgia (Barrett, Blake, Sweet) 971
CANCER
Hepatic Resection for Metastatic Colon Carcinoma (Cowgill) C-629
Marijuana for Nausea and Vomiting in Cancer Patients (Winokur, Baker, Lokey, Price) E-919
Multiple Endocrine Neoplasia Involving Steroid Producing Glands (Alonso) 917
Smoldering DIC Associated With Widespread Colonic Mucinous Adenocarcinoma (Krauss, Baisden, Otkin, Talledo) .. 699
Squamous Cell Carcinoma of the Thyroid Gland (Lee, Vohman, Pendergrast) 755
CANCER PAGES
Carbon Dioxide Laser in Gynecology (Burrell) C-317
Current Management of Nonseminomatous Testis Tumors (Schoborg, Rodriguez, Scott) C-137
Evaluation of the Abnormal Pap Smear — Colposcopy or Conization (Powell) ... C-399
A General Surgeon Looks at Breast Reconstruction (Underwood) C-725
Hepatic Resection for Metastatic Colon Carcinoma (Cowgill) C-629
How Often Should a Pap Test Be Done? (Powell) C-995
Reasons for Optimism in Childhood Cancers (Kim, Ragab) C-47
CARDIOLOGY
Echocardiography — Its Usefulness and Limitations (Stefadouros) H-777
Electrophysiological Diagnosis and Surgical Treatment of Recurrent Supraventricular Tachycardias Due to Wolff-Parkinson-White Syndrome (Rubin, Boineau, Stenson) 13
Georgia Heart Association Plans Nurse Conferences in Eight Georgia Cities 744
Heart Health Education for the Young, It's Important (Birge) H-631
Nutrition and Maintenance of Cardiovascular Health (Hunt) H-43
A Pilot Study of Early Ischemic Lesions in the Myocardium (Fatteh) 765
Recommendations for Phonocardiography (Silverman)
Transluminal Coronary Angioplasty (Fiedotin) H-723
Vasodilator Therapy of Chronic Congestive Heart Failure (Cabaniss) H-131
CERTIFICATE OF NEED
HEW Study Reports Certificate of Need Ineffective in Controlling Hospital Inflation 166
CIVIL WAR MEDICINE
The Medical Career of Samuel H. Stout, (Emmons) Part I 904
Mortality Rates of the U.S. Armies for the Year Ending June, 1862 (Woodward) .. 186
CLINICOPATHOLOGICAL CONFERENCE
Clinicopathological Conference (Fisher, Rao) 109
COLPOSCOPY
Evaluation of the Abnormal Pap Smear — Colposcopy or Conization (Powell) ... C-399
COMMUNICATION
To Comfort Always (Woody) E-306
COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
CSBME Disciplinary Actions 674
COMPUTERS
Computerized Literature Search in the Medical Community (Timm, Silverman, Davies) 377
CONFIDENTIALITY
The Confidentiality of Medical Review Committee Proceedings Under the Georgia Law (Berg, Zakas) L-711
CONIZATION
Evaluation of the Abnormal Pap Smear — Colposcopy or Conization (Powell) ... C-399
CONTINUING MEDICAL EDUCATION
CME/A Vital Necessity (Hammett) 865
The Round Peg, Square Hole Syndrome (Rosengart) E-719
COST AWARENESS
HEW Study Reports Certificate of Need Ineffective in Controlling Hospital Inflation 166
A Third-Party Perspective on Health Care Costs (Higginbotham) 367

— D —

DENGUE FEVER
Epidemiologic Note: Dengue Alert for Georgia 582
DERMATOLOGY
Current Trends in Dermatology (Pirozzi) .. 345
DIABETES
Oral Diabetic Agents: More Dangerous in the Elderly Than Recognized (Walker) 704
DIABETIC GLOMERULO-SCLEROSIS
Clinicopathological Conference (Fisher, Rao) 109
DIAZEPAM
Delayed Diazepam Withdrawal Syndrome: A Case of Auditory and Visual Hallucinations and Seizures (Chandora) 769
DIET (See, **NUTRITION**)
DISABILITY INSURANCE
Doctor Discusses Disability Dollars (Woodsides) 223
DRUGS
Delayed Diazepam Withdrawal Syndrome: A Case of Auditory and Visual Hallucinations and Seizures (Chandora) 769

— E —

ECONOMICS, MEDICAL
Medical Economics and Medical Ethics: Points of Conflict and Reconciliation (Pellegrino) 174
ECHOCARDIOGRAPHY
Echocardiography — Its Usefulness and Limitations (Stefadouros) H-777
Electrophysiological Diagnosis and Surgical Treatment of Recurrent Supraventricular Tachycardias Due to Wolff-Parkinson-White Syndrome (Rubin, Boineau, Stenson) 13

EDITORIALS
AMA — Atlanta — MAG — Winter Scientific Meeting (McGinnis) E-983
Commentary on Physician Advertising (DuBois) E-37
Correcting a Bad Impression (Matthews) E-982
Facility Fees — To Be or Not To Be (Dunbar) E-984
"Health for All" — Another Viewpoint (Rogers) E-307
Health Versus Radiation Hazard (Egan) .. E-125
An Introduction of the New MAG Officers E-568
Marijuana for Nausea and Vomiting in Cancer Patients (Winokur, Baker, Lokey, Price) E-919
Nutrition — An Overview of This Special Issue (Black) E-849
On Medical Ethics (Payne) E-780
The Paradox of Pharmaceutical Advertising (Woody) E-379
The Round Peg, Square Hole Syndrome (Rosengart) E-719
Shell Game on the Potomac (Dee) E-615
Should MAG Start Its Own Professional Liability Insurance Company? (Hollis) E-617
Smoke-Free Hospitals — The Time Has Arrived (Cohen) E-721
To Comfort Always (Woody) E-306
Zip Code 303 Welcomes You to the MAG (Wilson) E-223
EPIDEMIOLOGY
Epidemiologic Note: Dengue Alert for Georgia 582
ETHICS, MEDICAL
On Medical Ethics (Payne) E-780
Medical Economics and Medical Ethics: Points of Conflict and Reconciliation (Pellegrino) 174
State-Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgment (Harper) L-313
EYE BANK
Use of Eye Bank Sclera in Plastic and Reconstructive Surgery (Wesley, Benson, McCord) 118

— F —

FEDERAL BUDGET
Administration Cuts Proposed Health Budget 420
National Budget Highlights that Relate to Medicine 256
Shell Game on the Potomac (Dee) E-615
FEDERAL TRADE COMMISSION
Federal Trade Commission Broadens Its Front in Attack on Medicine 336
FOOD ADDITIVES
Real and Perceived Issues on Food Safety — A Nutrition Perspective (Forbes) 845

— G —

GEORGIA HEART ASSOCIATION (See, **AMERICAN HEART ASSOCIATION, GEORGIA AFFILIATE**)
GERIATRICS
Oral Diabetics Agents: More Dangerous in the Elderly Than Recognized (Walker) 704
GOVERNMENT, FEDERAL
Administration Cuts Proposed Health Budget 420
Federal Trade Commission Broadens Its Front in Attack on Medicine 336
HEW Study Reports Certificate of Need Ineffective in Controlling Hospital Inflation 166
Legislation Proposed to Reduce National Health Service Corps 258
National Budget Highlights That Relate to Medicine 256
Recent Developments in the Health Care Areas (Harper, Berg) L-785
Reconciling the Antitrust Laws and the Health Care Laws (Berg) L-127
Shell Game on the Potomac (Dee) E-615
Some Reminders and Helpful Tips Re Prescription of Controlled Substances 420
GRAVES' DISEASE
Orbital Decompression and the Treatment of Orbitopathy in Graves' Disease 27
GYNECOLOGY
Carbon Dioxide Laser in Gynecology (Burrell) C-317
Evaluation of the Abnormal Pap Smear — Colposcopy or Conization (Powell) ... C-399
How Often Should a Pap Test Be Done? (Powell) C-995

— H —

HEALTH CARE DELIVERY
Annual Rural Health Conference Set for April, 1980, in Boston 166
HEALTH CARE LAWS
Reconciling the Antitrust Laws and the Health Care Laws (Berg) L-127
HEALTH EDUCATION
Auxiliary to MAG Sponsors Two Health Education Workshops (Smith, Gay) 1012
Heart Health Education for the Young, It's Important (Birge) H-631
HEALTH INSURANCE
New Catastrophic Health Insurance Legislation Promises Substantial Savings 257
HEART PAGES
Echocardiography — Its Usefulness and Limitations (Stefadouros) H-777
Heart Health Education for the Young, It's Important (Birge) H-631
Hypertension: Morbidity, Treatment, and Compliance (Merrill) H-924
Nutrition and Maintenance of Cardiovascular Health (Hunt) H-43
Potassium-Rich Foods — Do They Do the Hypertensive Patient Any Good? (Heyden, Hames, Talton) H-395
Recommendations for Phonocardiography (Silverman) H-991
Therapy of Hypertrophic Cardiomyopathy — New Directions (Canedo) H-863
Transluminal Coronary Angioplasty (Fiedotin) H-723
HEAT-ASSOCIATED INJURIES
Heat Injury: A Possible Association with Lithium Carbonate Therapy (Lowance) 284
Heat-Wave Related Mortality — United States (CDC) 749
HEPATITIS, VIRAL
Viral Hepatitis Outbreaks — Georgia, Alabama (CDC) 117
HISTORY OF MEDICINE
A History of Medicine in Atlanta and Fulton County, Georgia Part I: Terminus to the Turn of the Century (Bryant) 273; Part II: Turn of the Century to Treachery (Bryant) 589
The Medical Career of Samuel H. Stout, (Emmons) Part I 904
Mortality Rates of the U.S. Armies for the Year Ending June, 1862 (Woodward) .. 186
HOSPICE
Hospice: Care for the Terminally Ill (Cowgill) 264
HOSPITALIZATION
Report of Some of the Effects of Georgia's New Civil Commitment Law on Patients in a Private Psychiatric Hospital (Davis) .. 385
What To Do and Not Do in the Emergency Treatment of Mentally Ill Persons (Berg) L-387
HYPERTENSION
Georgia Physician Receives Top Award in High Blood Pressure Control 337
Hypertension: Morbidity, Treatment, and Compliance (Merrill) H-924
Potassium-Rich Foods — Do They Do the Hypertensive Patient Any Good? (Heyden, Hames, Talton) H-395
Salt and Hypertension (Tobian) 827
Therapy of Hypertension, 1980 (Hall) 745

— I —

INFECTIOUS DISEASES
Campylobacter Enteritis (Lopez, Jackson) 597
Campylobacter fetus subspecies *jejuni* in Georgia (Barrett, Blake, Sweet) 971
Clinical Note: Brucellosis (Sendelbach, Alonso, Mallari, Foster) 371
Epidemiologic Note: Dengue Alert for Georgia 582
Toxoplasmosis in Pregnancy: Clinical Viewpoint and Report of a Chronic Case in Pregnancy (Tippins) 23
Viral Hepatitis Outbreaks — Georgia, Alabama (CDC) 117
INFORMED CONSENT
Informed Consent in Georgia: Previewing the "1980 Model" (Berg) L-34
INSURANCE
Medical Malpractice Insurers Need to Cooperate 659
Report on the Status of MAG-Sponsored Insurance Retirement and Pension Fund .. 256
Should MAG Start Its Own Professional Liability Insurance Company? (Hollis) E-617
INTERNAL MEDICINE
Clinicopathological Conference (Fisher, Rao) 109
INVESTMENTS
Investment Via Limited Partnership: Limited Deductions, Limited Liability, Limited Control (Armstrong) Part I L-859 Part II L-935
ISCHEMIC LESIONS
A Pilot Study of Early Ischemic Lesions in the Myocardium (Fatteh) 765

— J —

JEJUNO-ILEOSTOMY
Gastric Bypass: New Relief for the Undesirable Effects of Jejuno-Ileostomy (Wills) 301

— K —

KIDNEY
Calculi in a Non-Functioning Kidney (Clark, Waller, Someren) 359
Clinicopathological Conference (Fisher, Rao) 109

— L —

LABORATORY, STATE
State Laboratory to Charge Fees for Service 80
LASER TREATMENT
Argon Laser Treatment for Superficial Vascular Lesions 743
Carbon Dioxide Laser in Gynecology (Burrell) C-317
L-ASPARAGINASE
L-Asparaginase and Toxic Epidermal Necrolysis (Rodriguez) 355
LEGAL PAGES
The Confidentiality of Medical Review Committee Proceedings Under Georgia Law (Berg, Zakas) L-711
Dealing with Informal Requests From Attorneys for Production of Patient Records in Connection with Civil Litigation (Berg) L-987
Informed Consent in Georgia: Previewing the "1980 Model" (Berg) L-34
Investment Via Limited Partnership: Limited Deductions, Limited Liability, Limited Control (Armstrong) Part I L-859 Part II L-935
Not-So-Good News for the Good Samaritan (Berg) L-229
Recent Developments in the Health Care Areas (Harper, Berg) L-785
Reconciling the Antitrust Laws and the Health Care Laws (Berg) L-127
State-Funded Abortions: Judicial Acquiescence in the Sanctity of a Physician's Medical Judgment (Harper) L-313
Using Paraprofessionals as "Expert" Witnesses in Malpractice Cases (Berg) L-621
What To Do and Not Do in the Emergency Treatment of Mentally Ill Persons (Berg) L-387
LEGISLATIVE ACTIVITIES
Auxiliary Sponsors Workshop 888
Facility Fees — To Be or Not To Be (Dunbar) E-984
Legislation — A Continuing Involvement (Hammett) 941
Let's Stay Cool — But Involved (Hammett) 715
MAG Physicians Host Georgia Congressmen in Washington, D.C. 636
New Catastrophic Health Insurance Legislation Promises Substantial Savings 257
The 1980 Georgia General Assembly — Who Will Represent Medicine? (Kaufmann, Kidd) 9
1980 Medical Legislation Wrap-Up (Kaufmann, Kidd) 281
Physician Involvement Program (PIP) 1012
Report of Some of the Effects of Georgia's New Civil Commitment Laws on Patients in a Private Psychiatric Hospital (Davis) 385
LEUKEMIA
L-Asparaginase and Toxic Epidermal Necrolysis (Rodriguez) 355
LIABILITY (See also LEGAL PAGES)
Not-So-Good News for the Good Samaritan (Berg) L-229
LIBRARIES
Computerized Literature Search in the Medical Community (Timm, Silverman, Davies) 377
The Library Consortium — Service for Community Hospitals in Georgia (Rankin, Dykes, Reid) 965

LIVER
Hepatic Resection for Metastatic Colon Carcinoma (Cowgill) C-629
Viral Hepatitis Outbreaks — Georgia, Alabama (CDC) 117
LITHIUM CARBONATE THERAPY
Heat Injury: A Possible Association with Lithium Carbonate Therapy (Lowance) . 284

— M —

MALPRACTICE
Using Paraprofessionals as "Expert" Witnesses in Malpractice Cases (Berg) L-621
MARIJUANA
Marijuana for Nausea and Vomiting in Cancer Patients (Winokur, Baker, Lokey, Price) E-919
MEDICAL ASSOCIATION OF ATLANTA
Zip Code 303 Welcomes You to the MAG (Wilson) E-223
MEDICAL ASSOCIATION OF GEORGIA
ACTIVITIES
The Ball Is in *Your* Court (McDowell, Williams) 244
An Introduction of the New MAG Officers E-568
MAG Physicians Host Georgia Congressmen in Washington, D.C. 636
MAG Science Awards 420
Membership — A Top Priority (Hammett) 634
The 1980 Georgia General Assembly — Who Will Represent Medicine? (Kaufmann, Kidd) 9
1980 Medical Legislation Wrap-Up (Kaufmann, Kidd) 281
The 1979 MAG Scientific Assembly (Daniel) 64
Physician Involvement Program (PIP) .. 1012
Report on the Status of MAG-Sponsored Insurance Retirement and Pension Fund 256
Rusty Kidd Promoted to New Position at MAG 142
Should MAG Start Its Own Professional Liability Insurance Company? (Hollis) E-617
Symposium on Health Care in Correctional Institutions 167
Too Many Cooks Can Spoil the Broth (Atkins) 144
ANNUAL SESSION
Acceptance Speech of H. Hilt Hammett, Jr., M.D., for Office of President of the Medical Association of Georgia 566
The Allure of Atlanta (Dillon) 102
Component County Society Representation to the 1980 House of Delegates 94
Criteria for Selection of Recipients of MAG Awards 95
Directors and Delegates 96
General Information 91
Introducing Hoyt D. Gardner, M.D., as Guest Speaker 92
Official Proceedings:
Auxiliary Highlights 515
General Sessions
First 435
Final 558
Highlights of the 1980 Annual Session 432
House of Delegates
First Session 441
Second Session 469
Third Session 521
Photograph Index 423
Proceedings Index 421
Zip Code 303 Welcomes You to the MAG (Wilson) E-223
DEATHS
57, 143, 322, 406, 572, 636, 790, 868, 943, 1010
JOURNAL
Letters to the Editor 6, 654, 888
NEW MEMBERS
55, 141, 241, 321, 405, 571, 635, 717, 789, 867, 943, 1009
NEW MAG PERSONNEL 1011
PERSONALS
55, 141, 242, 321, 406, 571, 635, 717, 789, 867, 943, 1010
PRESIDENTS' LETTERS (See **PRESIDENTS' LETTERS**)
SCIENTIFIC ASSEMBLY
Medical Economics and Medical Ethics: Points of Conflict and Reconciliation (Pellegrino) 174
The 1979 MAG Scientific Assembly (Atkins) 64
Preliminary Program for the 1980 Scientific Assembly 679
SOCIETIES
57, 143, 242, 322, 406, 572, 790, 868, 943, 1010
MEDICAL REVIEW COMMITTEES
The Confidentiality of Medical Review Committee Proceedings Under the Georgia Law (Berg, Zakas) L-711
MEDICAL SCHOOLS
Educating the Student, Informing the Physician on Nutrition (Feldman, Levy, Curry) 837
The School of Medicine at Morehouse College: Status in 1979 and Plans for the Future (Sullivan) 673
Specialty and Location of Recent Medical School Graduates in Georgia — Implications for Primary Care (Jablonowski, Russell, Settles, Kay) 895
MEMBERSHIP
Membership — A Top Priority (Hammett) 634

— N —

NATIONAL HEALTH SERVICE CORPS (NHSC)
AMA Advises No Increase in NHSC Till More Studies Completed 888
Final Regulations Issued on Assignment of National Health Service Corps Personnel 258
Legislation Proposed to Reduce National Health Service Corps 258
NEONATOLOGY
Georgia's Newborn Screening Program ... 791
NEOPLASIA
Multiple Endocrine Neoplasia Involving Steroid Producing Glands (Alonso) 917
NEUROSURGERY
Surgical Treatment of Spondylolisthesis (Richardson, Brown) 193
NEWBORN SCREENING PROGRAM
Georgia's Newborn Screening Program ... 791
NURSING
The Nursing Shortage — Is There a Cure? 810
NUTRITION
Educating the Student, Informing the Physician on Nutrition (Feldman, Levy, Curry) 827
Nutrition — An Overview of This Special Issue (Black) E-849
Nutrition and Maintenance of Cardiovascular Health (Hunt) H-43
Nutritional Support of the Trauma Patient (Horowitz, Smith, Heymsfield) 815
Potassium-Rich Foods — Do They Do the Hypertensive Patient Any Good? (Heyden, Hames, Talton) H-395
Potential Barriers to Good Nutrition (Watson, Mossbrook, Johnson) 841
Real and Perceived Issues on Food Safety — A Nutrition Perspective (Forbes) 845
Salt and Hypertension (Tobian) 827

— O —

OBSTETRICS
Toxoplasmosis in Pregnancy: Clinical Viewpoint and Report of a Chronic Case in Pregnancy (Tippins) 23
OPHTHALMOLOGY
Orbital Decompression and the Treatment of Orbitopathy in Graves' Disease (McCord) 27
Use of Eye Bank Sclera in Plastic and Reconstructive Surgery (Wesley, Benson, McCord) 118
ORAL DIABETIC AGENTS
Oral Diabetic Agents: More Dangerous in the Elderly Than Recognized (Walker) 704
ORBITOPATHY
Orbital Decompression and the Treatment of Orbitopathy in Graves' Disease (McCord) 27
ORGANIZED MEDICINE
Medicine: It's a Beautiful Story (Gardner) 663

— P —

PAIN THERAPY
Biofeedback Therapy in Clinical Practice (Chapman, Rao) 668
PANCREATITIS
Association of Chronic Pancreatitis and Alcoholic Cirrhosis (Adams, Webster, Mainz) 759
PAPANICOLAOU (PAP) TESTS
How Often Should a Pap Test Be Done? (Powell) C-995
PARAPROFESSIONALS
Using Paraprofessionals as "Expert" Witnesses in Malpractice Cases (Berg) L-621
PATHOLOGY
Multiple Endocrine Neoplasia Involving Steroid Producing Glands (Alonso) 917
PEDIATRICS
Reasons for Optimism in Childhood Cancers (Kim, Ragab) C-47
PHARMACEUTICAL ADVERTISING
The Paradox of Pharmaceutical Advertising (Woody) E-379
PHYSICIAN ADVERTISING
Commentary on Physician Advertising (DuBois) E-37
PHYSICIAN RECOGNITION AWARDS RECIPIENTS
..... 66, 391, 639, 791, 873, 944, 1011
POTASSIUM
Potassium-Rich Foods — Do They Do the Hypertensive Patient Any Good? (Heyden, Hames, Talton) H-395
PREGNANCY (See **OBSTETRICS**)
PRESCRIPTIONS
Some Reminders and Helpful Tips Re Prescription of Controlled Substances 420
PRESIDENTS' LETTERS
A Beautiful Partnership (Hammett) 788
A Champion — Attitude and Desire (Hammett) 1008
CME/A Vital Necessity (Hammett) 865
I Had a Dream (Atkins) 320
Legislation — A Continuing Involvement (Hammett) 941
Let's Stay Cool — But Involved (Hammett) 715
MAG's Holy Grail (Atkins) 240
Membership — A Top Priority (Hammett) 634
My View of Leadership (Hammett) 404
Setting the Record Straight (Atkins) 54
Strength in Confidence (Hammett) 570
Too Many Cooks Can Spoil the Broth (Atkins) 144
PRIMARY CARE
Specialty and Location of Recent Medical School Graduates in Georgia — Implications for Primary Care (Jablonowski, Russell, Settles, Kay) 895
PRISON HEALTH CARE
Symposium on Health Care in Correctional Institutions 167
PROFESSIONAL LIABILITY INSURANCE
Annual Negotiating Session Between the MAG and St. Paul. The Continuing Saga of the Rising Rates (Underwood) 869
Medical Malpractice Insurers Need to Cooperate 659
Should MAG Start Its Own Professional Liability Insurance Company? (Hollis) E-617
PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO)
Of Special Interest . . . Congressman Writes MAG Member Re PSRO 80
Recent Developments in the Health Care Areas (Harper, Berg) L-785
PSYCHIATRY
Report of Some of the Effects of Georgia's New Civil Commitment Law on Patients in a Private Psychiatric Hospital (Davis) .. 385
The Seriously Burned Adult: Psychologic Reactions, Recovery, and Management (Tollison, Still, Tollison) 121
What To Do and Not Do in the Emergency Treatment of Mentally Ill Persons (Berg) L-387
PUBLIC RELATIONS
The Ball Is in *Your* Court (McDowell, Williams) 244
Communications Workshop for Auxiliary 656
PULMONARY DISEASE
A Cavitary Lesion in the Lower Lung (Stewart, Waller) 609
Pulmonary Rehabilitation: Dealing Effectively with Chronic Pulmonary Diseases (May, Kenny) 205

— R —

RADIOLOGY
Health Versus Radiation Hazard (Egan) .. E-125
REHABILITATION
Pulmonary Rehabilitation: Dealing Effectively with Chronic Pulmonary Disease (May, Kenny) 205
RELIGION
Correcting a Bad Impression (Matthews) E-982
Jehovah's Witnesses, How Can We Help Them? (Fatteh) 977
RETIREMENT
Retirement Plans Available to Medical Practices (Ott) 855

— S —

SAILING
What Do You Do For Encores? (Dickinson) 196
SMOKING
Quit Smoking Tips From the American Cancer Society 337
Smoke-Free Hospitals — The Time Has Arrived (Cohen) E-721
Who Smokes? 658
SOCIAL MEDICINE
"Health For All" — Another Viewpoint (Rogers) E-307
"Health For All by the Year 2000": Can We Afford Such a Future? (Bryant) 293
SPONDYLOLISTHESIS
Surgical Treatment of Spondylolisthesis (Richardson, Brown) 193
SPORTS MEDICINE
Heat Injury: A Possible Association With Lithium Carbonate Therapy (Lowance) 284
Richmond County Sports Medicine Preparticipation Physical Examination Program (Seklecki, Miller, Strong, Linder) 217
SURGERY
Electrophysiological Diagnosis and Surgical Treatment of Recurrent Supraventricular Tachycardias Due to Wolff-Parkinson-White Syndrome (Rubin, Boineau, Stenson) 43
Gastric Bypass: New Relief for the Undesirable Effects of Jejuno Ileostomy (Wills) 301
A General Surgeon Looks at Breast Reconstruction (Underwood) C-725
Hepatic Resection for Metastatic Colon Carcinoma (Cowgill) C-629
Surgical Treatment of Spondylolisthesis (Richardson, Brown) 195
Transluminal Coronary Angioplasty (Fiedotin) H-723
Use of Eye Bank Sclera in Plastic and Reconstructive Surgery (Wesley, Benson, McCord) 118

— T —

TESTIS TUMORS
Current Management of Nonseminomatous Testis Tumors (Schoberg, Rodriguez, Scott) C-137
THERAPEUTICS
Heat Injury: A Possible Association With Lithium Carbonate Therapy (Lowance) 284
Therapy of Hypertrophic Cardiomyopathy — New Directions (Canedo) H-863
THIRD-PARTY PAYORS
A Third-Party Perspective on Health Care Costs (Higginbotham) 367
THYROID
Orbital Decompression and the Treatment of Graves' Disease (McCord) 27
Squamous Cell Carcinoma of the Thyroid Gland (Lee, Vohman, Pendergrast) 755
TOXIC EPIDERMAL NECROLYSIS
L-Asparaginase and Toxic Epidermal Necrolysis (Rodriguez) 355
TOXOPLASMOSIS
Toxoplasmosis in Pregnancy: Clinical Viewpoint and Report of a Chronic Case in Pregnancy (Tippins) 23
TRANSFUSIONS
Jehovah's Witnesses, How Can We Help Them? (Fatteh) 977
TRANSPLANTABLE ORGANS
Post-Mortem Tragedies 17
TRAUMA
Nutritional Support of the Trauma Patient (Horowitz, Smith, Heymsfield) 815
The Seriously Burned Adult: Psychologic Reactions, Recovery, and Management (Tollison, Still, Tollison) 121

— U —

UROLOGY
Calculi in a Non-Functioning Kidney (Clark, Waller, Someren) 359
Current Management of Nonseminomatous Testis Tumors (Schoberg, Rodriguez, Scott) C-137
Too Bad For You, Humpty Dumpty (Morton) 901

— V —

VASECTOMY
Too Bad For You, Humpty Dumpty (Morton) 901
VOCATIONAL REHABILITATION
Rehabilitation in Georgia 338

— W —

WOLFF-PARKINSON-WHITE SYNDROME
Electrophysiological Diagnosis and Surgical Treatment of Recurrent Supraventricular Tachycardias Due to Wolff-Parkinson-White Syndrome (Rubin, Boineau, Stenson) 13
WORLD HEALTH ORGANIZATION (WHO)
"Health For All" — Another Viewpoint (Rogers) E-307
"Health For All by the Year 2000": Can We Afford Such a Future? (Bryant) 293

— X —

X-RAY SEMINAR
Calculi in a Non-Functioning Kidney (Clark, Waller, Someren) 359
A Cavitary Lesion in the Lower Lung (Stewart, Waller) 609

NUTRITION SERVICES CENTER

NUTRITION · SERVICES · CENTER
Emory University
SCHOOL OF MEDICINE

PHYSICIAN REFERRAL

• Computerized Nutrition Analysis
• Diet Therapy by Clinical Nutrition Specialists
• Hospital Consults

Nutrition Services Center
Emory University School of Medicine
1712 Clifton Road
Atlanta, Georgia 30329
Telephone (404) 329-5737

PHYSICIANS — SECOND CAREER OPPORTUNITY

We have a practice opportunity available at our Medical Unit in Reidsville, Georgia, that would be ideal for the Physician who wants to continue medical practice at a less hectic pace and seeks the advantages of a well-structured, daytime schedule of 40 hours per week.

Correctional Medical Systems is using its expertise to pioneer the delivery of quality medical care to one of the most neglected patient populations: prisoners. Physicians working with CMS receive excellent remuneration and paid professional liability insurance. The support staff includes PA's, RN's and on-site medical and administrative directors.

You can learn more about this unique medical specialty by calling Jack Monteith, TOLL FREE, at 1-800-325-3982. Written inquiries may be directed to:

CORRECTIONAL MEDICAL SYSTEMS
970 Executive Parkway • St. Louis, MO 63141

An Equal Opportunity Employer M/F

Index to Advertising

Vol. 69 **December 1980** **No. 12**

Anderson-Clayton Foods 999
Ballard, Walter, Optical Company 1014
Boehringer-Ingelheim 974-976
Boots Pharmaceutical 1003-1006
Brawner Psychiatric Institute 1000
Burroughs Wellcome Company 964
Classifieds 1013
Cherokee Log Homes 1024
Coca-Cola Company 981
Correctional Medical Systems 1020
Decatur Hearing Aid Service 955
Devereux Foundation, The 1015
Dickey-Mangham Company 1014
Fine, S. M., & Company 956
Fulton Federal Savings and Loan Association 1014
The Great Cherokee Trading Company 1000
Guffey's of Atlanta 980
Hickman-Datsun 1022
House of Persia 1000
Insurance Corporation of America 985
JMAG Classifieds 955
Lenbrook Properties 986
Lilly, Eli, and Company 958
Marion Laboratories 962
Metro Ambulance 959
Nutrition Services Center 1020
Ortega Pharmaceutical Company, Inc. 990
Peachtree and Parkwood Mental Health Center and Hospitals 969
PMMI/Med Data, Ltd. 961
Potter-Holden and Company 980
Psychiatric Institute of Atlanta 990
Ridgeview Institute 1007
Roche Laboratories 954, 955, 973, 1001, 1002
The Rocker Shop 961
Smith Kline & French 963
U. S. Air Force 970
Valley Psychiatric Hospital 980
Weight Watchers of Greater Atlanta 1022
Willingway Hospital 998
Wyeth Laboratories 993, 994, 1022, 1023

JOURNAL of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS — Articles are accepted for publication on the condition that they are contributed solely in this *Journal.* Manuscripts should be typewritten, double-spaced, and the original and one copy should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, date, volume (number, if available), and pages.

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the *Journal* will bill the author for this expense.

GENERAL POLICY — Authors will be given as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING — All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or negatives must reach the *Journal* office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE — If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

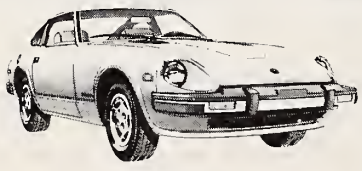
(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

LEASE A 1981

280 ZX ONLY $240.00

200 SX 40 mpg	$155	510	$158
210 51 mpg	$124	810 Maxima	$248
310 43 mpg	$139	BMW	$325



CALL
Gary Mack
455-1122

FOR DAILY RENTAL
INFORMATION
CALL MIKE THOMPSON

HICKMAN DATSUN
5211 Peachtree Industrial Blvd.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

Wyeth Laboratories
Philadelphia, Pa 19101

10 5368

UC San Francisco LIBRARY

UCSF Library
3 1378 00841 1244

370971